			For Stata Registrar	State of	of Marylan				lealth and M Death		giene Reg. No.	2007	34001
			Decedent's Name (First, Middle,	Last)						2. Date of De		Voss	3. Time of Death
	Physici		Nadine Cather	ine Park	cs					Month 10	9 Day	2007	8:15 P M
-	/Medic Examin		4a. Facility Name (If not institution,				4b. City.	Town, or	Location of Death		4c.	County of Death	
	LAGIIII	CI	Atlantic Genera				Ber	lin			1	Worceste	er
-	Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under	r 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		214-30-9504	1 ☐ M 2 🔀 F	80	Yrs.	Months	Days	Hours Min.	6. Date of Bit (Month, Da 5/13/1	927	200	MD
			Usual Residence of Decedent										
	ylen		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mai	ţo	MD Worce	ester	I	Berlin							1 ☐ Yes 2 🔯 No
	n the	lrec	10e. Street and Number				10f. Zip	Code			10g. Citiz	zen of What Cou	intry?
	death with the Marylend ims 23e or 28s-f show if must be notified at	a D	16 Anchor Way I	r.				2181	11			USA	
1	after death with the Maryler or Items 23e or 28s-f show officer must be notified at	ner	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of H	ispanic Origin? (Spanic Mexican, Puerto	ecify Yes or No Rican, etc.)	)- '	<ol> <li>Race - Amer Black, White</li> </ol>	
7.9	after or ite	F	1 Never Married 2 Marrie		2₽ No	ļ	1 ☐ Yes		Specify:				
2.c	ours	b	3 ☑ Widowed 4 ☐ Divorced	Year or I	Dates:							W.	hite
2.0 5-003	72 h natu	Completed by Funeral Director	15. Decedent's (Specify only highest	Education grade completed,	)	16a. Dece (Give	dent's Usu kind of wo	al Occupa	ation during most of work	ing	16b. Kii	nd of Business/I	ndustry
~ ~ ~ ~	ithin	du	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT		•			D	
727 200 200 12 br	filed with Hygiene. other than	S	12			Own	ner/0	perat		- /Cianh Adidalla		Bar	
2 % 5	be filed Ital Hyg od othe avant,	Be	17. Father's Name (First, Middle, Li					İ	18. Mother's Name		, Maideri	Sumame)	
118-19 10912 Maryland	2 should be filed within 72 hours after and Mental Hyglene. Is marked other than "natural", or ite aumatic avant, the Medical Examina	မ	Jospeh Farrel						Emma Tr			- 0	
0 0 p	- 4 4 =		19a. Informant's Name/Relationshi	p (Type, Print)					and Number or Run				
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ō	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation	B □Removal from		Place of Dispo cemetery, crei							own, state
<b>3</b> 3 <b>₹</b>	Pa tmen tant:		4 □ Donation 5 □ Other (Spe		Sur				ark   10/1			lin, MD	
DOB S DOD 10 Baltimore,	permit. Pages Depertment of Important: if it any injury or o		21. Signature of Funeral Service Li	censee /	1-1	1			ss of Facility Bu	_			
<u></u>	<u> </u>		JUIN 1	14(1)	100				am St., B			1811	Annovinate
			23a. Parti. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the dea each line.	th. Do not ent	ter the mo	de of dyin	ng, such as cardiac	or respiratory a	trrest,	*	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	, C	erebro	0 V C/5	culo	10	acci de	nt			
	/Medical Examiner		resulting in death)		(or as a consec								
	Examine		Sequentially list conditions.	b									
-	od iii	luei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consac	quanca of):							
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Dura to	(								
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\$ 00	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9⊟Unki	nant at time of one of the second of the sec	death 5L	Other (s	рөсту)					
10º	that it led by detac		Part II. Other significant condition	s contributing to	death but not re-	sulting in the u	ındarlying	Callee div	ren in Part I	23e. Did	tobacco u	use contribute to	the cause of death?
G 2. ₹	8 6 8	5	Tarri, other organical contains.	.e continuating to		ouning in the u	and drift and	sasso g	J	1	Yes 2	□No 3□Pr	obably 4 Unknown
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30-	e law hes b	혈								24a. Wa auto	psv	24b. Were au prior to death?	topsy findings available completion of cause of
Octine 17 - 1		ő								1 ☐ Yes	iormed? 2 No	1 Yes	2 No
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	ding P h. After t	e c	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o		28c. Injur Wor		28d. Describe	how injui	ry occurred	
<u>.0</u>	death.	catl	2 Accident investiga	ation		<u> </u>	М		Yes 2 □ No		10.		
Division	or Attanation death	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	208. Flat	e of Injury - At hidding, etc. (Spec	nome, farm, st hify)	reet, facto	ry, office			(Street an own, State		ıral Route Number,
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical E	xaminer: On the	basis of examin				me, date and place, opinion, death occur				
	thin 2 the the	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		20	o. Licens	se number		29d. Da	te signed (Mont	h, Dey, Year)
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			It- VOVIC	ymo	NOT IN	W			000	•	12	1 00	1 21211
	BA4		30. Name and address of person v	and completed car	- 1			1 1		CARRO	120	lin, me	1,2007 d 21811 i Drice
			31. Date filed (Month, Day, Year)	1 111 0	Registrar's Sign	intic (	Jene	YCI ]	Hospital,	41122	HCG	ITHURA	Drive
	Sta Regist		OCT 1 0	2007		K A	reele	,	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 7, 2007 **Physician** 7:15 Rachel Lee Peaper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LaPlata Charles 6860 Bumpey Oak Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Numbe **Funeral** Days Hours 1 ☐ M 2**X** F Yrs. 75 Sept.20,1932 New York Director 577-44-0406 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland LaPLata Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20646 Bumpey Oak Road Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No þ Specify: 3 ₩Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, the Medionce. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Kennel Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence C. War ဥ Tilling Andrew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6860 Bumpey Oak Road, LaPlata, Md. 20646 of Disposition (Name of Date 20c. Location - City or To Christine L. Webb Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Sec 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, M0668 20640 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a. Part1. Enter the shock, or heal Immediate Cause (F **Physician** 8 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy finding available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an available page 2 s autopsy funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28d. Describe how injury occurred Manner of Dea 28a. Date of Injury 28b. Time of 28c. Injury at Work? I Director: After to d in by the funera (Month, Day Year) or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire

State

To the Hospital

Baltimore, Maryland 21215-0036

P.O. Box 68760.

or Vital Records,

Division

Registra

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completely

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifie

Medical

**ORIGINAL** 

and manner stated

703

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

Year)

09

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 6:45pm M Jennie S. Petska 10/2/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heartfield at Bowie Bowie Prince George If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛱 F 91 (Month, Day, Year) 7/24/1916 Indiana Director 325-05-5384 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 🌪 🖸 No Director MD Anne Arundel Deale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be nonce. 824 Mason Ave. 20751 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married Married 1 ☐ Yes 21 No Specify: white þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Steffel Mary Wesserle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas B. Petska 824 Mason Ave. Deale, MD 20751 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 10/08/2007 Baltimore, MD 4 Donation 5 DOther (Specify) 22. Name and Address of FacilityHardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses Oal 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** audine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably ↑ | Wiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has rector, page 2 autopsy performed 2 or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 D N 6-ElOther (Specify) HSSUSTEC funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of enifier 29c. License number D57028

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

**ORIGINAL** 

# 231

Annapolis

Ridgely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 Registrar's Signature

Aditya Chopra 31. Date filed (Month, Day, Year)

OCT 0 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Theresa R. Picciotti 22:31 M October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex Months Days Hours 1 ☐ M 2 😿 F 142-36-1146 62 17, 1944 New Jersey Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 **USA** 5 Maple Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Janitorial Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Pedersen Joseph Lange 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Picciotti/Husband 5 Maple Avenue Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Oct. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Dother (Specify) 2007 21, Sign share of Farderal Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Approximate Interval Between Opser and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NUNB ANCER mos disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notifled at

other than "natu

27 is marked of traumatic even

permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau

Director

Completed by Funeral

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and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tran physician the attending | for use as ed by the a detached i signed I ate has b page 2 s

The law requires that the death certificate be executed

Box 68760.

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or Vital Records,

Division

certificate

Examiner Physician/Medical <u>\$</u> Completed Be 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification:

31. Date filed (Mor

Medical 29b. Signature and title 30. Name and address of STANZEY ATKI

5 Pending investigation

6 ☐ Could not be

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

29c. License number 311 DOC

29d. Date signed (Month, Day, Year) OctoBAR 3 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

CM

900 PBST GATE MD

Injury at Work?

1 ☐ Yes 2 ☐ No

PANNATURES mo 21401

28d. Describe how injury occurred

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2007 Richard Joseph Palazzo October 0 6, 8:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1XM 2□F Director 434-78-3890 March 13, 1949 Louisiana 58 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or Items 23a are not any injury or other traumatic areas. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Montgomery Damascus Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20872 USA 25905 Ridge Manor Drive, Unit C Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 □ No 1 ☐ Yes 2 🛣 No Specify: White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Golf Course 5+ Ranger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Angelo Joseph Palazzo Lottie Fae Selby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 9908 Biscayne Lane, Damascus, Maryland Karen Marie Smith Palazzo, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation Metropolitan Crematory 10/11/2007 Alexandria, Virginia 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Ignature of Juneral Se 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Inter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final **Physician** disease or condition resulting in death) Acute Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760. cal Physician/Medi attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year ξ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Illnknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Unknown Peritonitis Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 **X** No 1□ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 MOther (Specify)Hospice 1 Inpatient ٩ 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No i Director: A d in by the ft investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check onl one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m) D0064615 October 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, MD 1355 Piccard Drive, Rockville, maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**DCT 1 0** 2007

Please Type or Print in Black index in the state of the state of Maryland Department of Health and Mental Hygiene

Them 23a ner dr. . 2873, 11/106/276 Death

Reg. No. 2007 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 = For Amend Item 23a per dr., g873, 11/06/07 bb Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ctober 2007 William Cline Rebock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Washington County Hospital</u> Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 2 | Sept 2 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Yrs. Director 188-09-5019 91 1916 Pennsylvania Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n 212 Maple Avenue 21713 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14∏Yes 2 ☐ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or iten the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ₽ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Sandblasting Mfg. 18. Mother's Name (First, Middle, Maiden Surname)

Rebok

Catherine A. Reeder Rebock 17. Father's Name (First, Middle, Last) Be Joseph P. Rebock ۵ Rebok 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson L. Baker - POA 20019 Mill Point Road Boonsboro Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 10-12-2007 Hagerstown Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home allen 1331 Fastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cercon vascular accider /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Aspiration Pneumonia Exami Due to (das a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been siç , page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 24No 1☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner eath 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day 5 Pending investigation s after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Dav. Year) 1)62588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 B. Antietram Street, Hagerstown, no óH-3 + 1 MBAOUA, M JUDITH

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 1 2007

gistrar's Signature

assim

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician BILAL RAHIM OCTOBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number **Funeral** Hours Months 1**X** M 2□ F 22, 220-57-5638 27 DEC Director Sierra Leone Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 Sierra Leone 6137 Perry Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Abdul Rahim Fatmaha Kamara 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6206\ Darnells\ Grove\ Lane$  Bowie, MD 2072019a. Informant's Name/Relationship (Type. Print) Razak Rahim / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 10/5/2007 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Nat. Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD M01508 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER 5 Months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital o within 24 hours aft To the Funeral Di

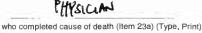
SCOTT 31. Date filed (Month State Registrar

re/and title of certifier

29a. Certifier

29b. Signatu

Medical



and manner stated.

29c. License number MD

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

32757

10/5/2007

DRIVE, BETHESDA, MARYLAND 20892

10 CENTER egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34008 Amend #1 &# 4 State of Mary and 10 epoctment Health and Mental Hygiene () () 7 1 - For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 4, Day **Physician** 2007 12:00 PM Nellie Joyce Ross NELLIE JOYCE ROSS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Woodsboro Frederick 303 North Main Streer 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min. 1 ■ M 2 🕮 F Months Days Hours 261-92-2110 June 4, 94 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No Director Maryland| Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 North Main Street 21798 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Allen Omer Hooper Elinor Joyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 North Main Street, Woodsboro, Maryland 21798 Jean Robertson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lexington Cemetery 10/9/07 Lexington, Kentucky \* 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate
Interval Between
Onset and Death
M 0 n M 8 Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) cerebovascula dineare Atherisclerotic due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 oran oru 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 D No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 1 Natural 2 Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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a funeral dir To the nospice, within 24 hours after death.

To the Funerel Director; All

**Funeral** 

Director

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Priysician /Medical

Examiner

Baltimore, Maryland 21215-0036

4 Homicide 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Ashe, MD

D0031058

10-5-07

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Woodsboro, MD 21798

State Registrar 31. Date filed (Month, Day, Year) OCT 1 0 2007

P.O BOX 32 Registrar's Signature 07-08021 Becky Ross

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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l Examii		Becky Rose  4a. Facility Name (if not institution, give stre	Ross	4b. City,	Town, or Location of D	October 14, 2	4c. County of Deat			
		Penninsula Regional Medical		Salis	bury		Wicomico			
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Und Mont	ier 1 Year   If Under 2	4Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Bi Forei	an		
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any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits		
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2 sho th and 27 is umati		Daniel Ross/Son		1016 Ada	ns Ave., S	alisbury, M	21804			
Healt F Healt Fitem er tra		20a. Method of Disposition  1 Burial 2 Cremation 3	•	ace of Disposition (N ematory or other place		Date 20	oc. Location - City o	or Town, State		
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OCME

			for State Registrar	State of	Maryland	-	artment rtificate			nd M	-	_	000	7	21.01	1
			Registrar  1. Decedent's Name (First, Middle)	. Last)			incate	OIL	Jean		2. Date of De	Reg. N	مک ن ز	1	3. Time of Deat	h
	Physic		Arlene Joyce								Month Octobe	D	ay 20	Year <b>07</b>	3:30 A	
	/Medi Exami		4a. Facility Name (If not institution		ber)		4b. City, T	own, or	Location of	Death	00000	_	c. County o		3.30	-
FC.			Suburban Hos	pital		i	Betl	hesd	la				Montg	omer	У	
	Funeral		5. Social Security Number		7. Age (In yrs. las		If Under 1 Months	Year Days	If Under 2	4 Hrs. Min.	8. Date of Bir (Month, Da	th			lace (State or For	eig
k	Director		578-44-8981	1 □ M 2 🔀 F	74	Yrs.			1.00.0		June 2	9,	1933	Wash:	ington,	D
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10	0d. Inside City Lin	nit
	Maryl f sho	ō	DC N/	΄Δ	Was	hingt	on								1 <sub>x</sub> Yes 2□	
	28a-	rec	10e. Street and Number	21	was	urugc	10f. Zip 0	Code				10g. C	itizen of Wi	nat Coun	try?	_
	h with	al D	3449 Holmead F	'1 NW			2	0010	0			II	S			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any orluny or other traumatic event, the Medical Examiner must be notifiled at once.	Funeral Director	11. Marital Status		dent Ever in U.S.	13. \				in? (Spe	cify Yes or No Rican, etc.)		14. Race	- America		_
9	after or Ite	/ Fu	1 □ Never Married 2 □ Marri		2 🔀 No		1 ☐ Yes 2		Specify:	ruentor	nican, etc.)		Specify:	A =	ican	
8	ural",	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dat	tes:				, ,					Ame	rican	
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ე ე	filed Hygi sther		17. Father's Name (First, Middle,			uper v	15019				(First, Middle,				vernment	_
an	ld be ental ked o	To Be	Robert Silas M	arshall					Fra	nces	Ross					
Baltimorė, Maryland 21215-0036	should ind Mer imarke	-	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Address (	Street a			Route Numb	er, City	or Town, S	tate, Zip	Code)	_
Σ	and 2 lealth a m 27 Is her tra		Karen P. Smith	/ Daughte	er	3449	Ho1mea	ad P	21 N	w w	ashing	ton	. DC	200	10	
J.	of He of He roth		20a. Method of Disposition	0 □ B	20b. Plac	ce of Dispo	sition (Name	e of			ate	20c.	Location - C	ity or To	wn, State	
Ĕ	Pages nent of P ant: If Its	-	1 <b>X</b> Burial 2 □ Cremation 4 □ Donation 5 □ Other ( <i>S</i> )		tate		Natio		i	ct.	9,2007	La	aurel.	MD.		
a	permit. Page Department Important: If any injury or		21. Signature of Foneral Service	icensee		22	2. Name and	Addres	s of Facility	McG	uire F	unei	ral Se	rvic	e, Inc.	
Ш	97 = 29	-	Indre	Mon	son	74	400 Ge	org	ia Ave	2.,	NW Was	shir	ngton,	DC	20012	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final		used the death. ch line. Stage I			of dying	g, such as c	ardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death	ì
	/Medical		disease or condition resulting in death)		r as a conseque		sema	-								_
l.	Examiner		On the Mark Hard State of the S	Con	gestive	Heart	t Fail	ure								
	<b>P</b> #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		r as a conseque						_					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	te Renal		Lure									_
8760,	cate be executed physician and the burial-transit	<u> </u>	robating in south, East		r as a conseque betes Me											
387	icate be executed physician and s the burial-transit	dical		d. Did	beces He	TITE	15									-
×	certif nding ise as	/Me	IF FEMALE:	23c. If yes, outco	ome pf pregnanc	cy							23d. Date	of dolivo	n,	
D. Box	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live bir	rth 2□Fetald unt at time of dea	eath 3□	Ectopic pre Other (spe						Mont		Day Year	
Vital Records, P.O	that the	F.	Part II. Other significant condition	ns contributing to dea	ath but not resulti	na în the ur	nderlying cau	use give	en in Part I.		23e. Did t	obacco	use contrib	oute to th	e cause of death	7
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Ö	w require been si should b	ete									240 14400		045 144			
æ	he fav e has ge 2 g	Completed								_	24a. Was autop		pr de	ere autor ior to con eath?	psy findings availa npletion of cause	of
<u>a</u>			25. Was case referred to medical						00 81	( D	1□ Yes	2 Z N		Yes	2 2 No	_
	Physician: The riths certificate har all director, page	o Be	examiner?  1 Yes 2 No	Hospital:	patient 2 ☐ EF	2/Outpation	t 3 □ DOA	Othe	DF:		(Check only only only only only only only only		o □o#	(0 : 1	,	-
Division or	ਰ ≑ ਰ	n: To	27. Manner of Death	28a. Date of	f Injury 2	8b. Time of		c. Injury Work			8d. Describe				/)	-
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N N	l or Attendatter deatt Director:	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place 0	of injury - At home	e, farm, str	eet, factory,	office		2	8f. Location (S City or Tox	Street a	and Number	r or Rurai	l Route Number,	
ō	talon rs afte al Di	Certification:			g, a.e. (apac)						Ony or 101	m, ola				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 X Certifyin (Check only one) 2 Medical	g Physician: To the b Examiner: On the bas and manne	sis of examinatio	edge, death n and/or in	n occurred a vestigation, i	t the tim in my op	ne, date and pinion, death	place, a occurre	and due to the ed at the time,	cause( date a	(s) and man nd place, ar	ner as st nd due to	ated. the cause(s)	
	To th Within To th	Me	29b. Signature and title of certifier				29c.	License	number			29d. D	ate signed	(Month, L	Day, Year)	_
	10		Po Lab	Donnos	. N	ID	D	$\alpha \gamma$	6299	39	1	Oct	oher	OL	200	7
,			30. Name and address of person	who completed cause	of death (Item 2	3a) (Type,	Print)									-
_			Petek Donmez, M	.D. 11119	Rockvi	lle P	ike #4	01	_Rocks	vi11	e MD.	20	0852			
	Sta	ite	31. Date filed (Month, Day, Year)	0 2007 32. Re	trar's Signatur	ге	- 40			-	-,					

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 0 9 2007

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pratima Pathak, M.D 1500 Forest Glen Road, Silver Spring, MD 20910

29c. License number D42688

29d. Date signed (Month, Day, Year) October 8, 2007

Physician /Medical	1. Decedent's Name (First, Middle, L			neg. N	10.L	3401
/Medical		ast)	epartment of Health and Certificate of Death	2. Date of Death Month	Oay Year 6,2007	3. Time of Death $5:55 \ a^{N}$
Examiner	4a. Facility Name (If not institution, ga	ive street and number)	4b. City, Town, or Location of Deat		c. County of Death	3:33 a
	3359 South Leis		Silver Spring	Date of Dieth	Montgom	
Funeral Director	217-28-8286	Sex   7. Age (In yrs. last birtho	Months Days Hours Min.	(Month, Day, Yea	1932 North	
or 28a-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. County  Maryland 10e. Street and Number	Montgomery Si	lver Spring 10f. Zip Code	10g. (	10 Citizen of What Count	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
st be		sure World Blvd.	20906		USA	
the rivigence of the manual of the manual of the modified at event, the Medical Examiner must be notified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ☑ No Specify:	to Rican, etc.)	14. Race - America Black, White, & Specification	etc.
other than "naturent, the Medical E	15. Decedent's l (Specify only highest g	College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)  COPTIONIST	rking	Kind of Business/Ind	ustry
e Co				me (First, Middle, Maid	Medical en Surname)	
arked o	1 7-1- 0 P 7-7	s	Theresa B	. Mueller		
is marked raumatic ev	19a. Informant's Name/Relationship		failing Address (Street and Number or R		y or Town, State, Zip	Code)
Department of them 27 is marked important: if them 27 is marked amy injury or other traumatic even once.	Charles N. Shea/ 20a. Method of Disposition 11 Direction 3 4 □ Donation 5 □ Other (Spec	☐Removal from State 20b. Place of D cemetery,	9 South Leisure Wo isposition (Name of crematory or other place) Octo Heaven Cemetery 20	ber 10,	Silver Spr Location - City of To Ver Spring	wn, State
/ inju	21. Signature of Funeral Service Lic	27	F2 Name and Address Co Figure 12			,,
E 8 8	Acens	polos ?	500 University Blv			MD 20901
us the burial-transit and transit and tran		b. Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	:			
been signed by the attending physicia should be detached for use as the but should be detached for use as the but should be physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
n signed hild be det		contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to th 2 No 3 Prob	e cause of death? ably 4 ∐Unknow
page 2				24a. Was an autopsy performed 1  Yes 2	prior to cor death?	osy findings availab npletion of cause of 2 No
director,	examiner?	Hospital:	Other:	ath (Check only one)		
ald ald	OZ Manara ( Danth	28a. Date of Injury (Month, Day Year)  28b. Tin	ne of 28c. Injury at	Home 5 Aresidence 28d. Describe how in		"
To the Funeral Director.  To the Funeral Director.  To the funeral Director.  To the funeral Director.  Medical Certification: T	3 Suicide 6 Could not 4 Homicide determine	be See Blood of injury. At home form		28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
o the Funers ompletely fille		Physician: To the best of my knowledge, caminer: On the basis of examination and/and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
Tot	29b. Signature and title of certifier	the Me	29c. License number D35635		Date signed (Month, a) Ctober 8,	
	30. Name and address of person wh Joseph Kaplan, 31. Date filed (Month Cay Year)	o completed cause of death (Item 23a) (Ty MD 18111 Prince	/pe, Print) Philip Drive, Olne	y, MD 20832	2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 34013 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0155 AM St. Clair 2007 >haron CHOrer 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Nashington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 2**⊠**F Country) 180-38-8810 60 June 8, Director 1947 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d, Inside City Limits PA **Funeral Director** Franklin Greencastle 1 ☐ Yes 2 XNo 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? 14367 Mercersburg Road 17225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Laminator <u>Stationary</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Kenneth Myers ပ္ Virginia Maun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14367 Mercersburg Road, Greencastle, PA 17225

Of Disposition (Name of 20c. Location - City or Town, State Department of Health Important: If item 27 any Injury or other tr once. George E. St. Clair/husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Macedonia Church 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 10/13/2007 Greencastle, PA 4 Donation 5 Dother (Specify) Cemetery 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. 21. Signature of Funeral Service Licensee 47 N. Park Ave., Mercersburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athrosele-ct.c **Physician** Laronsin /Medical Due to (or as a consequence of): Examiner \$1200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine he law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t autops performed? Yes No death? 1 ☐ Yes 2□ No 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?

Yes 2□ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 □ DOA Certification: To hours after death.

Ineral Director: After the filled in by the funeral 27. Manner of Death Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056763 0000 address of person who completed cause of death (Item 23a) (Type, Print) 251.€ 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

OCT

1 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>, 2007 Physician Emilian Stadnyk October 2:43 pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

July 19,1925 Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Country) Canada 577-48-5283 82 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mertal Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other than the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 24 No Director Kensington Maryland Montgomery 10e. Street and Number 10g, Citizen of What Country? 10f Zin Code 11205 Dewey Road 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ≥ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Picture Framing/ Elementary/Secondary (0-12) College (1-4or 5+) Art Gallery 12 <u>Proprietor</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Xenia Halushka Dmytro Stadnyk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11205 Dewey Road, Kensington, MD 20895 Lorraine Adeline Stadnyk/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a. Method of Disposition October 8 d 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2007 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licenses Approxim 2000 Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. In the design of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐**X**npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

Records, Division or Vital

0

29b. Signature and title of certifier

29c. License number 0 66 0 6 6

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd., Bethesda, MD 20814 Andrew Wong, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 8, 2007 Theresa Nora Saylor 0320 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Frederick
ler Year | fr Under 24 Hrs. | 8. Date of Birth
| Days | Hours | Min. | (Month, Day, Ye
| Feb 23, Calvert Mem. Hospital/Transitional Calvert 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2 🖸 F 578-26-4694 81 Wash. D.C. 1926 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Calvert Owings 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3920 Lower Marlboro Road 20736 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 2 should be filed within 72 hours after a nand Mental Hygiene.
Is marked other than "natural" or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Health Worker Federal Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William Dent Cheseldine Mary Μ. Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Marie Bostic (daughter) 3901 Lower Marlboro Road Owings, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Clinton, MD Fujeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Story J. Coli 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fallure Physician congostwe heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner stenosis 00. HC Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner COMMON be execu Due to (or as a consequence of): burial-1 Box 68760, physician Physician/Medical the as t IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 menths? Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed2 1□ Yes 2□ No certificate Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Hospital or Attending P thours after death. 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

dew 20

State Registrar

31. Date filed (Month, Day, Year)

MB

4107

110 . HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD # 310 206 FREDERICH MD PRINCE

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Merdono

		For State Registrar	State of Marylan		artment of H rtificate of			giene Reg. No. 2 N	7 31.016
		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
Physici /Medic		Glenna Jean S	h по и e п				OCTOBE	R 7, 2007	0035 M
Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dear		4c. County of D	
1.		MEMORIAL HOSPITAL			CUMBERL			ALLE	
Funeral		Social Security Number     6. Sex	M 257F	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Da		Birthplace (State or Foreign Country)
Director		2 1 3 - 4 0 - 3 6 1 0 Usual Residence of Decedent	67	115.			11-1	4-1939	MD
aryland show		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Mary First fied	ţ	MD Allegan	u C	umber	land				1 Yes 2 No
h the or 28s	Director	10e. Street and Number	2		10f. Zip Code			10g. Citizen of What	Country?
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	a [	512 Winifred Rd			215	02		USA	
tems fems er m	Funeral	1 Trimantal States	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - A Black, V	merican Indian, Vhite, etc.
s afte	by F	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify: ()	lhite.
hour tural	ed to	15. Decedent's Educ		16a. Dece	dent's Usual Occu	pation		16b. Kind of Busine	ess/Industry
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al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Surname)	
uld b Menta Irked	To E	Robert Wilson	Shroyer			Mary	Catheri	ne Shaff	er
s 1 and 2 should be filed within 72 hours after death with the Man f Heatth and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified		19a. Informant's Name/Relationship (Ty			•			er, City or Town, Star	
and lealth m 27		Linda K. Deist/						berland,	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee.		20a. Method of Disposition 1   Burial 2 □ Cremation 3	emoval from State		osition (Name of ematory or other pla		Date	20c. Location - City	
t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Specify)	Hı	indmai	n Cemte	ry : 10.	-9-2007	Hyndmar	r, PA er Funeral
Depariment of the policy of th		21. Signature of Funeral Service License	Attento	2	2. Name and Addre	ess of Facility H	arvey t	1. Leigle	er tuneral
		23a. Part1. Editer the disease or complishook, or heart failure. List only or	cations that caused the deat	h Do not en	tor the mode of dui	2 Clare	nce St.	, Hyndmo	Approximate
		shock, of heart failure. List only or Immediate Cause (Final	ne cause on each line.	I A	Wan D	TIAL	1 6 1 1 1	ARCTION	Interval Between Onset and Death
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Examiner			Due to (or as a conseq	uence oi).					
	ية	Se prentially list conditions if any, leading to immediate	Due to (or as a conseq	uence of):					
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The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		I						
leath certific attending p	Med	IF FEMALE:	0-11						
attenc for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Feta	aldeath 3	Ectopic pregnand	cy		23d. Date of Month	delivery Day Year
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uires sign Id be	d by						10	Yes 2∐No 3[	Probably 4 Unknown
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an: T tificat or, pa	Ö	25. Was case referred to medical				26 Place of De	1 Yes eath (Check only	2 No 1 □	Yes 2☑No
Physician: The law requir this certificate has been si al director, page 2 should I	O B	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2 Z	ER/Outpatie	nt 3 DOA Ot	h		idence 6 Other	Specify)
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page									
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nds	6 5	30. Name and address of person who co				berland.	MD 215	02	
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		For		State	of Marylar	nd / Dep	artment of I	Health and	d Mental H	lygier	ne				
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Physici	ian	Decedent's Nam							2. Date of I Month	[	Day	Year	3. Time of		
/Medio		4a. Facility Name (/			LOU umber)		SCHARF 4b. City, Town, o	or Location of De	10	10		07 y of Death	0327	M	
Examin	ler	WMHS BR					CUMBE					LLEGAI	NY		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home,													
9 9 E E B		Walut C. School 404 Decatur Street, Cumberland, MD													
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r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ned 286. Plac	e of injury - At h	ome, farm, str	eet, factory, office		28f. Location	(Street	and Num	ber or Rura	al Route Num	ber,	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Medical	29a. Certifier (Check only one)	2   Medical	g Physician: To the Examiner: On the	ne best of my kno basis of examina nner stated.	owledge, deal ation and/or ir	h occurred at the to evestigation, in my	ime, date and pla opinion, death o	ace, and due to the ccurred at the time	ne, date	e(s) and m and place	nanner as s , end due to	tated. o the cause(s	;)	
To the Within To the Comple	Me	29b. Signature and	I title of certifier				29c. Licens	se number		29d. I	Date sign	ed (Month,	Day, Year)		
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VI Kramaditya Poonai M.O. 924 Seton Drive, Cumberland, M.O.  31. Date filed (Month, Day, Year)											7		
Sell		30. Name and addr	ress of person	who completed cau	use of death (Iter	n 23a) (Type,		Cal	. 0 = '	/	} ,	i	12	1502	
MA Sta	ate	31. Date filed (Mon	madı nth, Day, Year)	TYA 32.	Registrar's Signi	ature	J. 494	DETON	1 DRIVE	21	unl	Derlan	od, MI	<u> </u>	
Registi		OCT	1 2 200	17 See	J. J.	Good									

			For State Registrar	State of Ma	ryland / De	epartment of Pertificate	of Health <i>of Deatl</i>	and Mo		en <b>20</b> 07	34018
	Physicia /Medic		1. Decedent's Name (First, Middle, Charles Henry S						2. Date of Death Month October	Day Year 4, 2007	3. Time of Death 5:25 P M
	Examin		4a. Facility Name (If not institution,	give street and number)			wn, or Location			4c. County of De	
			Carroll Hospita		(In um last highe		stminst		8. Date of Birth	Carrol	
	Funeral Director		5. Social Security Number 216-28-4665 Usual Residence of Decedent	1.XIM 2□F	(In yrs. last birtho	Months [	Days Hours		June 11	, 1932	irthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
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	or 28	Directo	10e. Street and Number			10f. Zip C	ode		10	g. Citizen of What (	Country?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates: 1	0	13. Was Deceder If Yes, specify 1 ☐ Yes 20			Rican, etc.)	Black, Wh	
Baltimore, Maryland 21215-0036	2 hou	edt	15. Decedent	s Education	16a. D	ecedent's Usual (	Occupation		1	6b. Kind of Busines	
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<u>Ş</u>	nould d Men narks natic	ဥ	Frank P. Sheldo		105.00	Indian Address /			Cooling	City of Town Ctate	Zin Code)
Wai	d 2 st th and 7 is n treun		Joyce Sheldon/							City or Town, State,	
6	1 an Heal tem 2		20a. Method of Disposition	ATTE		isposition (Name crematory or othe		-		Oc. Location - City of	
20	ages ent of nt: if if		1 🕅 Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		1	crematory or other. Cemeter	1	10-9	-2007 C	hesaneake	e City, MD
量	mit. Fortante porter injur.	- 1	21. Signature of Funeral Service L		/.	22. Name and	Address of Fac	ility			012), 112
m	Depa Impo any i		Kuchard	2. 600	die	318 Geo:	oard Fu rge Str	neral eet. (	Home, P Chesapea	.A. ke City,	MD 21915
8760,	/Medical Examiner the private and ithe purial-transit	ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mind) that initiated events resulting in death) Last	a. Jeal  b. Due to (or as a	a consequence of) a consequence of)	NCU e	L ( <i>/</i> .	gne	ea (1)	WTWINT	Cohset and Death  (Ye Co
.O. Box 6	the death certifi by the attending ached for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal déath	3 □Ectopic preg 5 □ Other (spec				23d. Date of d Month	lelivery Day Year
<u>α</u>	uires that signed b d be deta		Partil. Other significant condition	s contributing to death bu	it not resulting in th	ne underlying cau	se given in Par	rt I.	23e. Did toba	acco use contribute	to the cause of death?
ğ	w require been sig should b	led l	HIStory V	Heady	Mu (	- Ance			1 🗆 Yes	2 No 3	Probably 4 Unknown
Il Records,		Completed by							24a. Was an autopsy perform	prior to	
Vital	iclan: Th	Be	25. Was case referr on medical examiner?	Hospital:			Other		(Check only one		
o	유무등	tion: To	1 Yes 2 No  27. Manne Death 1 atural 5 Pending investig.	28a. Date of Injur (Month, Day	v 28b. Tim	_	c. Injury at Work?	2	ne 5 □ Resider 28d. Describe hov	ce 6 ⊡Other (Sp vinjury occurred	pecify)
Division	of or Attendi efter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be 200 Block of Init	iry - At home, farm :. (Specify)	, street, factory, o	office	2	28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or Attending I within 24 hours efter death. To the Funerel Director; Atter completely filled in by the funer	Medical C	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best of examiner: On the basis of and manner sta	examination and/o	death occurred at or investigation, in	the time, date in my opinion, d	and place, a	and due to the cau ed at the time, da	use(s) and manner se and place, and d	as stated. ue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier			29c. 1	License numbe		29	d. Date signed (Mo	nth, Day, Year)
			<b>P</b> /				1)6.	303	1	14)	16001
/	041VA		Yousuf Gotto	the completed cause of de	South	Center	Street	et V	Vistmi	nster 1	ND 21157
	Sta	te	31. Date filed (Month, Day Gar)	9 2007 32. Hagistra	r's Signature	Sporte					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $200\overset{Year}{7}$ STEPHENS **Physician** LEE SANDRA OCTOBER 10 45A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 29, 9. Birthplace (State or Foreign Country) Massachusetts 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕅 F 1941 Director 014-32-2049 Usual Residence of Decedent 10b. County 10d. Inside City Limits la or 28a-f show t be notified at 10a. State 10c. City, Town or Location 1 XYes 2 No Lady Lake Director Lake FL 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code d 2 should be filed within 72 hours after death with I th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or : traumatic event, the Medical Examiner must be n 32159 USA 616 Saint Andrews Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Clerical Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Beatrice Falk Clayton Eugene Cate ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum 616 St. Andrews Blvd. Lady Lake, FL 32159 Jonathan C. Stephens/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 10/09/07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.0. Box 78421. Signature of Funeral Service MO/25/ Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a consequence of : /Medical Examiner multiple Sequentially list conditions, Due to (or as a conse sence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed extrasiv burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4∰Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 251 page 2 certificate has 1□ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending Injury 1 Natural 1 ☐ Yes 2 ☐ No hin 24 hours after death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 4 31. Date filed (Month State 1 0 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Alice Anderson Steely October 5:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 5. Social Security Number . Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Months 1□M 2√F 150 24 1207 Feb. 13. 1934 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d Inside City Limits 1 ☐ Yes 2 ☐ No Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 2611 Legends Way 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Commercial Estate Bank of America 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence S. Anderson Ella Mae Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Smith/daughter 2611 Legends Way Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 SeBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gards 10/12/2007 Marriottsville, MD 21. Signature of Funeral Service Licenses M01442 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 23a. P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

death certificate be executed

attending physician

ğ

certificate has

After this

Hospital or Attending

death.

24 hours after death e Funeral Director: filled in by the

the

P.O. Box 68760

Division or Vital Records,

Physician

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

d 2 should be filed w h and Mental Hygier is marked other th

Pages '

Baltimore, Maryland 21215-0036

Examiner þ Completed Be 2

burial-transi Physician/Medical the as page 2 should director, funeral Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1☐ Yes 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner?

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier

29c. License number

701

N. Charles V.

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

men

Registrar

Medical

31. Date filed (Month, Day, Year) OCT 2007 32. Rajistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2007 34022 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Irene Elizabeth Stewart 8, 2007 2:00 October\_ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5805 Leslie Lane Carroll Mount Airy If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🗶 F 20, 1901 Washington, DC Director 216-32-6569 106 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rthen "natural", or Iteme 23e or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryalnd Carroll Mt. Airy 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21771 5805 Leslie Lane Funerai 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or iten eny injury or other treumatic event, its Medical Examinations. Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify. δ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 owner/operator gift shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Thomas Mahoney Barbara Louise Saur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24908 Woodfield School Road, Damascus, MD Natalie E. Hoover, Daughter 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/12/2007 Brentwood, Maryland 22. Name and Address of FacilityMolesworth-Williams Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. E e the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dr h art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carse (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner DAYS. Dementer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 2 0 24a. Was an autopsy performed? penomics. 1 □ Yes 2-5 No : After this certification tuneral director. 25. Was case referred to medical 26. Place of Death Check on one examiner 1 Yes 2 No examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٥ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident nerel Director; / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after To the Hospital within 24 hours a To the Funerel C 1 🕇 Certifying Physician: 🄀 the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and it 29c. License number 29d. Date signed (Month, Day, Year) 10/8/07. D0050207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1502 S. main Street Mt Airy MD DRISAMUEL EWG, MD. 32. Regeltrar's Signature 31. Date filed (Month) 2007 Registrar

le Sanders	1	State of Maryland / Department of Health and M 1-For State Certificate of Death	Mental		20	07 3402
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of De	ath	3. Time of Death
edical Examin	ıer	Dale Dawneen Sanders		Month October		1350 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca 2908 Brightseat Road # 103 Landover	ation of De	eath	4c. County of D Prince Geo	
Funeral			f Under 24	Hrs. 8. Date of B	Birth (MM/DD/YXYY) 9	. Birthplace (State or preigr <b>Washington,</b>
Director		578-88-1587 1 M 2 XF 34 Yrs. Months Days F	Hours   N	Novem	ber 14,	Country) D.C.
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
od show a	_	Maryland Prince Georges Landover				1 X Yes 2 No
Aaryland 28a-f sh	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of What	Country?
th the Ma		2908 Brightseat Road; Apt. 103 20785			United S	
ath wit items	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispania If Yes, specify Cuban, Met			lo- 14. Race - A White, e	merican Indian, Black, tc.
ifter de		3 Widowed 4 Divorced of Yes, Give Year or Dates:	pecify:		Specify:	Black
hours a	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (during most of working life DO			16b. Kind of Busin	1
36 nin 72 l f. than "1 dical E	bet	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade Customer Service			1 -	- Us Stores
5-00 ed with tygiene other	Completed				, Maiden Surname)	
121; d be fil ental F arked	8	Weyland Jeff Hawkins	Vane			
PD 2 shoul and M 27 is m	]ع	19a. Informant's Name/Relationship (Type, Print )  Sherry Sanders Smith (Sister)  5509 Axton Cour				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter	erv.	Date ct.22,20	20c. Location - Ci	
MOF Pages bent of unt: If or othe	П	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  George Washington C	- 1	-		P.G.,Maryland
Salti ermit. Pepartm mports njury o		21. Signature of Funeral Service Licensee 22. Name and Address of F				y Morticians,
Physician	-	Xcursland F. Acutal Inc.; 600 Ken 23a. Part I. Enter the sease, or compliant is that caused the death. Do not enter the mode of dying, such				Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. <u>Diabetic ketoacidosis com licating Hy</u>				Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of): cardiovascular disc	ease	SIVE GLICE	OSCIETOLIC.	
	<u>ء</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in (agth.) Last Due to (or as a consequence of):				
executed an and al - transit	Ĭ	events resulting in death) Last Due to (or as a consequence or):  d				
6 be executed ysician and burial - transit	edical	X UNPENDED AMENDED #23a, 27, perME, 8872, 10/25/07 TT				
6876( certificate nding physise as the b	n/Me	23b. Was decedent pregnant in the	Ectopic pre	egnancy	23d. Date of de Month	livery Day Year
Box 6876 death certificate the attending phy	Physician/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
. 2 52	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Dio	I tobacco use contribu	te to the cause of death?
P.O.	d b			_ 1 _ Y	'es 2 No 3	Probably 4 Unknown
v requi	Completed			24a. Wa aut	as an 24b. We	re autopsy findings available or to completion of cause of
Recc The law	E O				formed? dea	ath? Yes 2 No
Division of Vital Records, spital or Attending Physician: The law requirement after death.  Peral Director: After this certificate has been stilled in by the funeral director, page 2 should be	Be	examiner?	hor:	eck only one)		
ision of Vital Attending Physician: r death. ector: After this certif by the funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at		ursing Home 5 28d. Describ	Residence 6 🗸	
on c ending ath. or: Af	틶	1 X Natural 5 Pending (Month, Day, Year)				
Visi	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buildi	ding, etc.	28f. Location		or Rural Route Number, City
Di ospital hours a		4 Homicide determined (Specify)  29a. Certifier Countries Devision Table has of pulse and days death accuracy of the time date.		113		
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, eath occurr	and due to the ca ed at the time, da	ause(s) and manner as te and place, and due	s stated. e to the cause(s)
To vit	Me	and manner stated.  29b. Signature and title of certifier  29c. License nu	umber		29d. Date signed	(Month, Day, Year)
		(and Hallan O.C.M.E	E.		October 13,	2007
)		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore	MD 21	1201		
St.	ate		., IVID Z	1201		
Regist	rar					

DHMH 17 Rev 1/2001 OCME 2006

DCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#4a, perMD, 10/9/07, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 29 Month 1 **Physician** 7005 B Dower Donald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Ave Asbury Methodist Vill Russell Montgowern 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Bighplace (State or Koreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F 003-01-4218 87 Dec. 11, 1919 New Jersey Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f show mit. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 XNo Director MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 333 Russell Avenue 20877 United States Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□No WW II 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Institutes of Health Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Sheldon Tower Edith Jones r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah T. Fretwell/Daughter 803 Elane Way, Benicia, CA 94510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory October 3 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 TRACY HUNER 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endstag disease or condition resulting in death) /Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, if any the ling to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-trai Due to (or as a consequence of): Box 68760, physician s the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) P.O. signed by the a d be detached f 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Vital Records, 4 Ninknown 1 ☐ Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2/2000 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) Manner of Ceath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical /2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29 20+1

State Registrar

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

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31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) UCICER 2140 M **Physician** 200 OHN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Friendship 173 Friendship Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Unde Days Hours **Funeral** Days Months Min. 1 2 F 78 27,1928 Maryland Director Nov.214-30-3017 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. • Ither than "natural", or items 23a or 28a-febour 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 □Yes 2XNo Friendship Director Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number b or U.S.A. 20758 173 Friendship Road permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) agriculture farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Marie Ward ဥ Calvert Tucker, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 173 Friendship Rd., Friendship, MD 20758 Barbara M. Tucker, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10-08-07 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home. P.A. Lure of Funeral Service Licens 20736 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt foliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 elm **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes detached 9□Unknown 9 TlJnknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atterwithin 24 hours after des To the Funeral Directo completely filled in by the 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) DEFENSETIGH WAY ANNAPOLIS MOZIYOF 32. Registraris Signature 31. Date filed (Month, Day, Year) State 2007▶ OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14, 2007 Eugene Thomas October 5:45 A Harry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Beverly Living Ctr. of Cumberland Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1⊠M 2□F Director 162-16-8759 89 12/1/1917 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 ∑Yes 2 No Cumberland Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Frederick Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1944— If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. ģ 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Paint and Glass Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental H Edward Thomas Helen Elizabeth Trail ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 1240 Oakland Terrace Road, Baltimore, MD 21227 Gary W. Thomas / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any injury or otl 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet. Cem @ Rocky Gap 10/17/2007 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Tome, F.A. 21. Signature of Juneral Service Licenses 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bladden Carcinome Immediate Cause (Final YV. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any read to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of certificate be executed Examl and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 | Yes 2 | No 3 | Probably 4 | Pinknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has page 2 autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 14 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760. Division or Vital Records,

Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year) State OCT 1 5 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical



and manner stated.

10033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Oct 14 2007

625 Kent Avenue, Cumberland, MD

29c. License number

Sunil K. Gupta, M.D., Registrar's Signature



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9/28/2007 **Physician** 1950 Joyce E. Tobin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Somerford Assisted Living Date of Birth (Month, Day, Year) 6/1/1925 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. last birthday) 6. Sex Social Security Number **Funeral** Hours Days Nebraska 82 1 M 2 7 Vrs 508-24-5997 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 TiYes ZXXNo **Annapolis** Anne Arundel Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 1970 Scotts Crossing Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No <u>Ş</u> 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Zeleny James Koutsky ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, MD 21401 Suite 400 621 Ridgely Ave. Eric P. Grevin Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/5/2007 Annapolis, MD Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final aechac a tons **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ed by the atten detached for u Month Year in the past 12 p onths? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 27. Manne of Death Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 □ Suicide 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number e of certifier 29b. Signature

State Registrar

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31. Date filed (Month, Day, Year)

OCT 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1	ViSi or Att fler de direct	<u> </u> <u>;</u> ≌	2 Acciden 3 Suicide		28e. Place of	Injury - At I	nome, farm,	street, facto	ry, office bui	lding, etc.	28f. Location ( or Town, S		r Rural Route Number, City
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#	Hosp 24 hc Fun			Certifying Physic	ian: To the best of	my knowle	dge, death o	occurred at the	he time, date	e and place, and	d due to the cau	se(s) and manner as	stated. to the cause(s)
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate betwithin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physicist or the the funeral director. After this certificate has been signed by the attending physicist or the funeral director. Days 2 should be detached for use as the burit.	Medical	one) 2	Certifying Physici  Medical Examine	r: On the basis of e and manner state	xamination d.	and/or inves				at the time, date		(Month, Day, Year)
	F × F 3	ĮΣ	29b. Signature	and title of certifier	1 /	/		2	9c. License			October 4, 20	
			/	1///		h->			O.C.N	ı.c.		Colober 4, 20	
-	DCME	4		address of person who	completed ause of	f death (Ite	m 23a)	444.5	n C+	Poltimers N	MD 24204		
				V .	outvenief Me			111 Pen	n Street,	Baltimore, N	VID 2 1201		
	Regi	State		Month Pay, Year) 9		trar's Signa	ture	Manage	End !				
	74-10	N 18 18 1			14								

		-	For State Registrar	State	of Marylan		artment of F rtificate of	Health and N <i>Death</i>		iene eg. No. 🗘 .		
			negistrar     Decedent's Name (First, Midd)	le, Last)					2. Date of Deat	th 4	007	3.3 mbo 6 a 2 9
	Physicia	an		_					Month 10	05 2	Year 2007	12:15 P M
	/Medic		Velma May  4a. Facility Name (If not institution		umber)		4b. City, Town, o	or Location of Death			ty of Death	12.13 F
	Examin	er				4401				Car	rrett	
			Garrett Cou 5. Social Security Number	nty Memor	7. Age (In yrs.	last birthdav)	If Under 1 Year	Land If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Funeral Director		218-28-1492	1 □ M 2 🙀 F	76		Months Days	Hours Min.	(Month, Day, 11–19–		Coun	* *
ja.			Usual Residence of Decedent	L					11 17	1750	Mary	Land
	land ow		10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation				1	0d, Inside City Limits
	Mary f sh	to	Md Garre	tt	MT.	Lake	Park				1	1 □ Yes 2 □ Nio
	the 28a notif	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	f What Cour	ntry?
	with 3a or		904 Philadel	lohia Ave			21550	)		U.S.A		
	ns 2: mus	Funeral	11. Marital Status	12. Was De	cedent Ever in U	.S. 13.		Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-	14. R	ace - Americ	
	r Iter	ᆵ	1 ☐ Never Married 2 ☐ Mar	Armed F rried 1 ☐ Yes	2 No		Y		o Rican, etc.)		lack, White,	etc.
036	al", o	þ	3 Widowed 4 ☐ Divorce	d If Yes, G Year or	aive Dates:		1□Yes 2□No	Specify:		Spec	Whi	te
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decede	nt's Education	0	16a. Dece	dent's Usual Occup	pation during most of work	king	16b. Kind of	Business/In	dustry
215	within 7 iene. • than "n the Medi	ble	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT use retire	daning most of word	Ning			
21	d withir giene. er than the Me	PO.	12		<u> </u>		Homemaker	Υ — — — — —		Self		
p	be filed that Hygid ed other event, the	Be	17. Father's Name (First, Middle	, Last)				18. Mother's Nam	ne (First, Middle, i	Maiden Surn	ame)	
<u>a</u>	should be land Mental s marked o	2	Arthur W. Cul	Lp Sr.	_			Pearl	V. Hart	man		
Maryland	es 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic e		19a. Informant's Name/Relation				•	t and Number or Ru		-	-	
	and 2 ealth n 27 l		Paul E. Lille	er Jr.				hurch,Ste				
Baltimore,	of He	9	20a. Method of Disposition	2 Dameuel free	20b. I	Place of Disponentery, cre	osition (Name of matory or other pla w Cemete:	ace)	Date	20c. Location	n - City or To	own, State
Ĕ	permit. Pages 1 Department of P Important: If Ite any Injury or ot		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (		I State F	airvie	w Cemeter	ry 10/8	/2007	0akla	ind, Mo	d.
alti	mit.		21. Signature of Juneral Service	Licensee	1) -	2	2. Name and Addre	ess of Facility S	tewart F	uneral	Home	
m	o a T e	6	Wm /f/	rello	DX D		32 S.	Second S	treet, 0	akland	l, Md.	21550
	-		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the deat	th. Do not en	ter the mode of dyi	ing, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final	( )								Onset and Death    NowTHS_
	/Medical		disease or condition resulting in death)	a. Due t	o (or as a consec		INCONY.	WITH ME	141141	//		1 · NONIH)
10	Examiner			1								
		je.	Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events	b. Duc t	o (or all a nunseo	nionca offi						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	<b>5</b> .								
oʻ	exec		resulting in death) Last	Due to	o (or as a consec	quence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d	_			_				
9	tificar g phy as th	ledi			_							-
Box	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregn		⊒Ectopic pregnanc	24			Date of deliv	
	deat e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 X No	4□Pre	gnant at time of		Other (specify)				Month	Day Year
0	at the de by the tached	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unk								
о, С	res that igned b	by P	Part il. Other significant condi	tions contributing to	death but not res	sulting in the u	ınderlying cause gi	ven in Part I.				he cause of death?
ĕ	quire n sig uld b	d be	COAD E	NA STE	IGE				1 U Y	es 2□No	3 ☐ Pro	bably 4 dnknown
00	w requir s been si should I	lete							24a. Was a		b. Were auto	opsy findings available
Re	he lav e has	Completed							autop	rmed? 2 <b>X</b> No	death?	ompletion of cause of 2□ No
Vital Records,	sician: The certificate har rector, page		25. Was case referred to medic	al				26 Place of Dea	1∐ Yes ath (Check only or		1 🗆 1 62	2 140
5	s cert irect	o Be	examiner? 1 ☐ Yes 2 🔭 No	Hoopital:	☑ Inpatient 2 ☐	TER/Outpatie	nt 3 DOA Ot	hor-	lome 5 ☐ Resid		Other (Speci	fv)
o	Phy er this eral d	. To	27. Manner of Death	28a. Dat	te of Injury	28b. Time			28d. Describe h			<i>,,,</i>
on	nding th. : Afte	tior	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Me tigation	onth, Day Year)	Injury		ork? ]Yes 2∐No				
Division	Atter dea ctor	fica	3 ☐ Suicide 6 ☐ Could	d not be mined 28e. Pla	ce of injury - At h	ome, farm, st	reet, factory, office	•	28f. Location (S City or Tow	Street and Nu	mber or Rur	al Route Number,
Ö	al or after Dire	Certification;	4 ☐ Homicide deter	Bui	iding, etc. (Speci	1197			City of You	m, otate)		
	spita nours nera y fille		29a. Certifier 1 Certify	ring Physician: To t	he best of my kn	owledge, dea	th occurred at the	time, date and place	e, and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, is	Medical	(Check only 2☐ Medica one)	ai Examiner: On the and ma	e basis of examin anner stated.	auon and/or i	nvestigation, in my	opinion, death occ	urreu at the time,	uate and plac	se, and due	to trie cause(s)
	To the within To the Comp	M	29b. Signature and title of certif	ier	0	W.	29c. Licen	ise number		29d. Date sig	ned (Month,	Day, Year)
	_	1	) ()/a() S	MIST	NOSO	WIN	)   11 1	6154		10	18/07	
		7	30. Name and address of person	n who completed ca	ruse of death (Ite	m 23a) (Type	, Print)				0101	
		1	DAUL DAMES	11115-	Don 1	9 WO	/ . A .	ES 111 1	AKLAW	1 me	1 21	550_
	Sta	ate	31. Date filed (Month Day, Yea	9 2007 32	. Registrar's Sign	ature	1 4					
	Regist	rar	001 -	\$ 4007	SSIRP.S	103 A	330000					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month VALENTINE **Physician** EUGENE 1 HOMAS 2007 OCTOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL | IT Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 7, 19 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. New Jersey 140-24-2713 76 1930 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other than "natural", or items 23a or 28a-f show vent, the Me ical Examiner must be notified at Florida Pinellas St. Petersburg 1 XYes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7400 Sun Island Drive #801 33707 United States Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 ant: If item 27 is marked other than "natural", or other traumatic event, the Men loal Examiner must ury or other traumatic event, the Men loal Examiner must Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Assisted College (1-4or 5+) Elementary/Secondary (0-12) 12 Owner/Operator Living Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angelo Dennis Valentine Ida Smaniotto ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Sessler / Daughter 12363 Pleasant View Drive, Fulton, Maryland 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. October 0 1 TBurial 2 Cremation 3 □ Removal from State Sacred Heart Cemetery Vineland, New Jersey 4 □ Donation 5 □ Other (Specify) 8, 2007 Vineland, Crouch Funeral Home 21. Signature of Furnal Service in 6 22. Name and Address of Facility 127 South Main Street, North East, Maryland21901 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition RENAL **Physician** MONTH resulting in death) /Medical Due to (or as a consequence of): Examiner ULTIPLE MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LORTIC STENOSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2X No DIABENES MELLIT 24a. Was an autopsy performe HYPERTENSION 1 Yes 2 No Be 26. Place of Death (Check only one)

Division or Vital Records, To the Hospital or Attending Physician:

Medical Certification: To

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

27. Manner of Death 1 Natural

2 Accident 3☐ Suicide 4 ☐ Homicide

29a. Certifier

5 ☐ Pending investigation 6 Could not be determined

Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ∏Yes 2 ∏No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

I 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MEDICAL DOCTOR

28c. Injury at Work?

OCTOBER 3, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL HOLDHOFF

600 NORTH WOLFE STREET BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

9 2007

, M. D

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** October 2007 9:00 P. Melrae Wasserman /Medical Center 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Nursinf & Rehabilitation Montgomery Kensington If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months 1 M 2 T Director 93 Dec. 12, 1913 Tennessee 525-44-7139 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director Maryland Montgomery Silver Spring the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 2201 Colston Drive, # 411 20910 U. S. A. Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. nd 2 should be filed within 72 hours after of the and Mental Hygiene. 27 is marked other than "natural", or Iter traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lerner Corporation Bookkeeper 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenny Simon James B. Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is m
any injury or other traum
once. 13809 Bonsal Lane, Silver Spring, Maryland 20906 Deanye S. Lawrence - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 ▼Removal from State King David Mem. Gdns 10/8/2007 Falls Church, Virginia d 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction, Inc. 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Biliary Cancer Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform performed? 1∐ Yes 2 ♣ No ueat⊓? 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural n 24 hours after death.

In Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MDrdeep October 5, 2007] D0064624 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sandeep Sharma 400 W. 7th Street, Frederick, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elever It fores 2007 Registrar

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician  $P^{M}$ Sept. 24, 2007 2:19 Weedor Wangolo /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Springbrook Adventist Nursing Home 8. Date of Birth (Month, Day, Year) Feb. 12, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 1 F 69 Liberia 1938 Director 216**-**45-3249 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 No Director Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number Funeral 6800 Brown Wood Road 20772 Liberia 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sabah Kolu Coryor Boi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20772 6800 Brown Wood Rd. Upper Marlboro, MD. George Wangolo / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/2007 | Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave., NW Washington, DC 20012 hon 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 hr **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Years Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Years Dementia Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month ę Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Division or Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier - 5 M D17874 October 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3717 38th Ave., Cottage City, MD.

DHMH 17 Rev 1/2001

State

Registrar

S. M. Nayar, M.D.

OCT 0 9 2007

31. Date filed (Month, Day, Year)

32. Restrar's Signature

20b. Place of Disposition (Name of cemetery, crematory or other place)

Be

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Albert Owen Monroe

Rudolph C. Worch, III/Son

1 Burial 2 □ Cremation 3 □ Removal from State

Jarboe, M.D.

James P. 31. Date filed (Month, Da

19a. Informant's Name/Relationship (Type. Print)

**Physician** /Medical **Examiner** 

burial-tra

Physician/Medical Examiner

Medical Certification: To Be Completed by

funeral director, page 2 should be detact 10

Division or Vital Records, P.O. Box 68760,

4 □ Donation 5 □ Other (Specif		Gate	of I	Ieaven	Cemete	ery 2	0Ó7	Silver	Spring,	MD
21. Signature of Funeral Service Licer	nsee		F#2	Name and Add ANCIS Univ	ersity	lins 1 Blvd	Fune	ral Hor Silve	ne Inc Spring	, MD
23a. Part1. 3 ter the disease, or com shock, or heart failure. List only	plications that chused one cause on each lin	the death. De	o not enter	the mode of d	ring, such as care	diac or respi	ratory arre	st,	Approximat Interval Bet	ween
Immediate Cause (Final disease or condition resulting in death)	_a	EAR	ral	ory to	reles	de,			Onset and t	<b>5</b> ,
	Due to (or as a	only:	Alle	EHE	art f	aile	W	<u>ئے</u>	hs	K
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	e of):	om	yora	ther	7		4	<b>)</b> ,
resulting in death) Last	Due to (or as a	consequence	e of): Dva	ry F	Max	11	2	,	4/2	D
IF FEMALE:				1"	/	/			-A	
23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome   1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnar Other (specify)				23d. Date of Month		Year
Part II. Other significant conditions	contributing to death bu	it not resulting	in the und	derlying cause of	iven in Part I.	23	Be. Did tob	acco use contrib	ute to the cause of c	leath?
						_  _	1 ☐ Ye	s 2 No 3	☐ Probably 4 ☐ l	Jnknown
						_	la. Was an autopsy perform Yes 2	ed? de:	ere autopsy findings or to completion of c ath? ]Yes 2☐ No	available ause of
25. Was case referred to medical examiner?					26. Place of I	Death (Chec	ck only one	)		
1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/0	Outpatient	3□ DOA C	ther: 4X Nursin	ng Home 5	Reside	nce 6 Other	(Specify)	
27. Manner of Death 1		Year) 28b	o. Time of Injury	28c. In W	ury at ork? ⊒ Yes 2 □ No	28d. De	escribe ho	w injury occurred	ı	
3 Suicide 6 Could not b 4 Homicide determined		ry - At home, :. (Specify)	farm, stree	et, factory, offic	е	28f. Loc Cit	cation (Str ty or Town,	eet and Number State)	or Rural Route Num	ber,
29a. Certifier 1 de Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner sta	examination.	lge, death and/or inve	occurred at the estigation, in m	time, date and pl	place, and du occurred at ti	e to the ca he time, da	use(s) and manr ite and place, an	ner as stated. d due to the cause(s	;)
29b. Signature and title of centifier	narlar	los	445	29c. Lice	nse number 064 l	19		d. Date signed (	Month, Day, Year)	
30. Name and address of person who	completed cause of de	eath (Item 23a	(Type, P	rint)		-				

18. Mother's Name (First, Middle, Maiden Surname)

20c. Location - City or Town, State

Floyd May Fariss

9

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.o. Box 2256, Leonardtown, MD 20650

Oct. Date

State Registrar

24035 Three Notch Road, Hollywood, Maryland 20636

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 34034 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Marv Catherine Warner 8. October 2007 2040 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS- Memorial Campus Allegany Cumberland If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/02/1918 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 □ M 2 🗓 F 89 Yrs. Maryland 214-05-5215 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No MD Allegany Cumberland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1012 Frederick Street 21502 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 No if Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify 2 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Meg Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Litten Emory Condy Potts Nettie ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Potts / Brother 5129 N. Bleck Road, Michigan City, IN altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 10/12/2007 Cumberland, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD CA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 | Yes 2**X** No Division or Vital To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54411 October 10, 2007 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beverly Calkins, M.D., 500 Memorial Avenue, Cumberland, MD Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2007 1 Registrar

State of Maryland / Department of Health and Mental Hygier 🖟 🕦 Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:32 P M 2007 October 0 Mary Elizabeth Wolf /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Garrett County Memorial Hospital 0akland 8. Date of Birth (Month, Day, Yea May 15, 1 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖫 F <sup>′</sup>Virginia Ĩ930 215-58-6402 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 77 is marked other then "naturel", or Items 23e or 28e-f ehow freumetic event, the Mayloal Extrainer transt be notified at TY□Yes 2□No Director MD Garrett Mtn. Lake Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21550 United States 1009 Broadford Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" ~ " any injury or other freumetic even." 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Amy Rumer David Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1009 Broadford Rd., Mtn. Lake Park, MD 21550 Mr. Irving Wolf, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/2007 Oakland Cemetery Oakland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
David A. Burdock Funeral Home 21. Signature of Funeral Service Licensee Sweiter 21 N. Second St., Oakland, MD 21550 Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been sign 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has al director, page 2: autopsy 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2010 2 ER/Outpatient 1 Inpatient 3C DOA ို 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 / Homicide within 24 hours a

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completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 311 North Fourth St., Oakland, MD 21550 Thomas G. Johnson, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007 OCT - 9

			For State Registrar	State	of Maryla	ind / Depa <i>Cei</i>	artment of tificate of	Health and M Death	R	eg. No.	007	34036
	Physici	_	1. Decedent's Name (First, Middle,	Last)					2. Date of Deal Month	Day	Yeer	3. Time of Death
) ).	/Medic	al	Alma Arlen  4a. Facility Name (If not institution,				4b. City, Town	or Location of Death	10		07 Inty of Death	12:24 A
	Examin	er	484 Gorman St	•				land		Gan	rrett	
	Funeral Director		5. Social Security Number 233 70 0255	6. Sex 1 ☐ M 2 ☐ ¥	7. Age (In yr 93	s. last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth 2 / 19 / 19	1 <sup>Year)</sup>	9. Birth Cou Ma	place (State or Foreign ntry) ysville WV
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	cation					10d. Inside City Limits
	Maryis f sho	or	Md Garre	ett		0aklan						1 ☐ Yes 2 ☐ No
	r 28a-	irect	10e. Street and Number		1		10f. Zip Code		1	0g. Citizen	of What Cou	intry?
	th with	al D	484 Gorman S	Street			215				S.A.	
36	should be filed within 72 hours after deeth with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show imatic event, it a Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed	cedent Ever in Forces? 2 (4No Give		Was Decedent of If Yes, specify Cu X 1 ☐ Yes 2 ☐ N	Hispanic Origin? (Suban, Mexican, Puerto o Specify:	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White Bc <i>ify:</i> Wh	
ş	2 hour	ted t	15. Decedent	s Education		16a. Dece	dent's Usual Occ	upation		16b. Kind o	f Business/Ir	ndustry
21215-0036	ithin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)			e during most of work red)	king	Se.	1 £	
2	filed wi Hygien other th		17. Father's Name (First, Middle, I	act)		HO	memaker	18 Mother's Nam	ne (First, Middle,			
Maryland	Mental Parked of arked ot	To Be	Jacob U.Jones	Last)				Gracie	A. Hawk			
	ind 2 sho eith and 27 is m		19a. Informant's Name/Relationsh Thelma M. Wilt	Daughte Daughte	er	19b. Mailir 338	ng Address <i>(Stre</i> Gorman	Street Oa	kland, M	d. 2	wn, State, Zi 1550	ip Code)
altimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 is marked any injury or other traumatic ev		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		I .	-	matory or other p	tery 10/0			on - City or T	
Balti	pemit. F Departme Importar any injur		21. Signature of Fun art S. rvio-1		100		2. Name and Add		Stewart	Funer		me
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	be sit	lner	Securitary fish monotions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 1	o (or as a cons	equence of):	0					
ő	ficate be executed physician end is the burial-transit	I Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a cons	equence of):						
8760,	physic physic the b	dlcal		d								
.O. Box 6	Attending Physicien: The law requires that the death certif rdeath. •ctor: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	outcome of precent of precent of the	etal death 3	□Ectopic pregnar □ Other (specify)			23d.	Date of deli	very Day Year
ls, P.(	res that th igned by be detacl	۵	Part II. Other significant condition	ins contributing to	death but not r	resulting in the u	inderlying cause	given in Part I.	23e. Did to			the cause of death?
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l Rec	The law ete has t page 2 s	Completed			Ver	renty				sy med? 20 No	prior to c death? 1 \(\sum \text{Yes}\)	topsy findings available ompletion of cause of
<u>ita</u>	cien: ertific ector,	Be	25. Was case referred to medical examiner?	Hoositali					ath (Check only or	ne)		
of	Physic rthis c ral din	5 T	1 ☐ Yes 2 No  27. Manne of Death		Inpatient 2	ER/Outpatie	III JU DOA		fome 5 Resid		Other (Spec	cify)
0	ding th. : After s fune	Itlon	1 Natural 5 Pendin 2 Accident investig	g (M	onth, Day Year,	) Injury	V	vork? □Yes 2□No				
Division of Vital Records, P.	l or Atter efter dea Director I in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined   200. Fla	ice of Injury - Ailding, etc. (Spe	t home, larm, st ecify)	reet, factory, office	ce	281. Location (S City or Tow		um <i>ber</i> or Ru	ral Route Number,
	To the Nospitel or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my lead to basis of exame anner stated.	knowledge, deat ination and/or in	th occurred at the	time, date and place y opinion, death occu	a, and due to the curred at the time, o	cause(s) and date and pla	d manner as	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	A			29c. Lice	ense number		29d. Date si	gned (Month	n. Day, Year)
	C > F 0		•	1/hu	~n_		i	21233	3	10	01810	0 )
		1	30. Name and address of person	who completed ca	ause of death (I	Item 23a) (Type,	Print)					
		X	311 North Four	32	akland, . Aggistrar's Sig		50 D	r. Thomas	Johnson			
	Sta Regist		31. Date liled (Month, Day, Year)	9 2007	. Inglistical a Gli	J. 4.	See By					

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Physician/	Re	gistrar Decedent's Name	e (First, Midd	ie,Last)					Mont	of Death	av Year	3. Time of I	
Medical Examiner	1	JOSEPH		ALOYSUS		WA	ATERS 4b. City.	Town, or Location of		ber 9, 20	4c. County of De		
1	4	a. Facility Name (i 7801 Barlov		on, give street and nu 117	nber)			tsville			Prince Geor	_	
Funeral	5	Social Security N	lumber	6. Sex		yrs. last bir	thday) If Und Mont	ter 1 Year If Under	Afin		MM/DD/YYYY) 9. For	Birthplace (Sta eign MARYI Country)	LAND
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any	_	sual Residence o 0a. State	10b. County		100	c. City, Town	or Location					1	City Limits 2 No
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h the Maryland 3a or 28a-f sh ottlifted at ones	1	0e. Street and Nu 7801 BARI		#101				p Code 785		1	S.A.		
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or items 23		1 Never Marr		1 Yes	2X	No		2 X No specify:		,	Specify.BLA	CK	
hours after 'natural'', Examiner		3 Widowed		vorced If Yes, Give Yes or Dates: ecify only highest gra		eted) 16a	. Decedent's Usua	al Occupation (Give	kind of work dor	ne 1	6b. Kind of Busine		
5-0036 ed within 72 hours afty tygiene. other than "natural" he.Medical Examine	3	Elementary/Sec						orking life. DO NOT		ļ	DDTVATE		
5-0036 led within 72 tygiene. other than '	<u> </u>	7th		e Last)		S	ERVICE T	ECHNICIAN 18.Mother	r's Name (First,	Middle, Ma	PRIVATE niden Surname)		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	וא	JOSEPH A	. WATE	RS SR.				FLOSS	SIE M. H	UGHES	S City at Town S	State Zin Code	\
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mad 2 sho lealth and tem 27 is traumati	цĒ	20a. Method of Di	sposition	W/MOTHER_	_	20b. Place		ame of cemetery,	Date		20c. Location - Cit	ty or Town, Sta	te
Baltimore, osemit. Pages I an Department of Hee Important: If ite Important: If ite Injury or other tr	1		Cremati 5 Other	on 3 Removal f	rom State	; ]	NY MEMOR	RIAL CEM.			LANDOVER :		
taltir	t	21. Signature of F	uneral Service	ce Licensee				nd Address of Facilit					
	-	23a, Part I. Enter	the distase,	or complications that	caused th	ne death. Do	not enter the mod	de of dying, such as	cardiac or respi	ratory arres	st, shock, or heart	Approx Between	imate Interval
Physician Medical	ı	failure. List o	only on caus	se on each line.			diovascula						Death
kaminer		or condition resul			a conseq	uence of):							
	اج	Sequentially list of if any, leading to cause. Enter Un	immediate	Due to (or as	a consec	uence of):						1	
	Examine	(Disease or injury	that initiated	Due to for or	a consec	quence of):							
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50, te be executi yysician and burial - trai	Nedical	X UNPENDE	:D	#23a.	PII,2	7.perME e of pregnan	.g872, 10/	24/07 TT			23d. Date of de		
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Box 6876 te death certificate the attending phy ned for use as the	Physician/M	1 Yes 2		Unknown g Uni	nown		o Other to			220 Did to	bacco use contribu	ute to the caus	e of death?
, P.O. I				ditions contributing				ying cause given in I	Part I.		2 No 3		
rds, Frequires requires been sign	ted	<u>Dial</u>	oetes me	ellitus: chro	nic a	TCÓUOTT	SII		_	24a. Was a		ere autopsy fin	dings available in of cause of
COLC e law re e has be ge 2 sho	Completed by								<del></del>		med? de	ath? ✔ Yes	2 No
tal Rec	Be Co	25. Was case re	ferred to med					26.Place of Dear				011 8	
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nding Pl nding Pl th.		27. Manner of D  1 X Natural	5 🔲 F	Pending	ite of Injui	ear)	, , , , , , , , , , , , , , , , , , ,	1 Yes 2	No				
Division of Vital Records, tal or Attending Physician: The law requirers after death. In this certificate has been similar birector: After this certificate has been similar in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Certification:	2 Accident		nvestigation 28e. P	ace of Inj	ury - At hom	e, farm, street, fac	ctory, office building,	, etc. 28f.	Location (S or Town, S	Street and Number State)	r or Rural Rout	e Number, City
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate thours after death. Funeral Director: After this certificate has been signed by the attending physell	Certi	4 Homicid	le	g Physician: To the			death acquired s	at the time, date and	place and due	to the caus	se(s) and manner	as stated.	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check only one) 2	✓ Medical	g Physician: To the Examiner:On the bas and mann	is of exar	mination and	or investigation, i	in my opinion, death	occurred at the	time, date	and place, and de	20 10 110 01100	(s)
To with To con	Me	29b. Signature	and title of ce	rtifier				29c. License numb	oer		October 11		, Year)
			ing "	is, m				O.C.M.E.			October		
CR.		30. Name and a	ddress of pe	rson who completed o	ause of d kamine	r 111 F	ರಾಗಿ Street, E	Baltimore, MD 2	1201				
Sta		31. Date filed (A				r's Signatur	ed						
Regist		UUI	7 9 70	OCME			ORIGINAL						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1:00 pm September 30, 2007 4c. County of Death 4b. City, Town, or Location of Death Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sex

**Physician** /Medical Examiner

**Funeral** 

Director "natural", or items 23a or 28a-f show diral Examiner must be notified at

filed within 72 hours after death with the Maryland the Medical permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any linjury or other traumatic event, the once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Examiner certificate be executed and burial-1 P.O. Box 68760, physician as attending nse for the þ Division or Vital Records, certificate has page 2 s

this funeral o After death. after death the filled in by Hospital or To the Hospital within 24 hours at To the Funeral D 6

1. Decedent's Name (First, Middle, Last) William Paul Yochum 4a. Facility Name (If not institution, give street and number) 12324 Pretoria Drive 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours Min 1 X M 2 □ F 78 November 5,1928 Pennsylvania 159-22-1368 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U.S.A. 12324 Pretoria Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes. Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 ☑ No Specify: 2 White 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) United States Government Senior Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Murray William P. Yochum ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1611 Old Bay Lane, Severn, Maryland David P. Yochum - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 10/05/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Namou Silver Spring, Maryland 20904 11800 New Hampshire Avenue, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final disease or ondition resulting in death) Acute Cerebrovascular Accident Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2□ No 1☐ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 X No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 5, 2007 D24997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luis Casas, M.D., 8317 Cherry Lane, Laurel, Maryland 20707

DHMH 17 Rev 1/2001

State

Registrar

32. Resistrar's Signature

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"0"9 2007

State of Maryland / Department of Health and Mental Hygiene Santiago Bonilla Zavala 2007 34039 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 11, 2007 0633 hrs Medical Examiner Zavala Bonilla Santiago c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring Washington Adventist Hospital 9. Birthplace (State or Foreign E If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Salvador Days Months Hours Director 197 1 X M 2 F 27 02 none Dec. Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County any 1 X Yes 2 No permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Marlboro Prince George's Upper 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Salvador ö 9436 Victoria Drive Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 X Yes 2 No specify: Salvadoran Specify: White Divorced If Yes, Give Year Widowed à 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Tile Company 4th Ceramic Tile 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Blanca Olivia Zavala Bonilla Valentin BOnilla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9436 Victoria Dr. Upper Marlboro Md. 20772 Maria S. Bonilla de Velasco 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-22-07 El Salvador Family Cemetery Donation 5 Other Specify: 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th St. N.W. Washington DC 20010 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Death failure. List only one cause on each line. Medical Heroin and alcohol intoxication immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED. #23a,27,28a-f, perME.g872, 10/25/07 TT the attending physician ned for use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 ✔ Unknown ⋧ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an this certificate has been a director, page 2 should prior to completion of cause of autopsy performed? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) e Hospital or Attending Physician: 124 hours after death. 25. Was case referred to medical Be Other 4 Hospital: 1 examiner? Residence 6 Nursing Home 5 ER/Outpatient 3 V DOA After this c funeral dire inpatient 2 1 ✔ Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 X No Natural unk Pending Director: d in by the f FNd 10/11/2007 Fnd 5:45 a.m 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. XCould not be 3 Suicide or Town, State) determined (Specify) 2214 Phelps Rd. Hvattsville. MD House To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 12, 2007 O.C.M.E. 30. Name and agdress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32, Registrar's Signature

Registrar

			For State Registrar	State of Ma	aryland /		rtment of F		ind Me	ental Hyg	giene Rog. No 2 (	007	341	040
	Physici	an	1. Decedent's Name (First, Middle, Las	t)		-				2. Date of Dea Month	Day	Year	3. Time of	
*	/Medic	al	David Allen  4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location o		10/20/2		nty of Death	10:30	) P <sup>M</sup>
*	Examin	er	Glen Burnie Rehab	Sheet and numbery			Glen Bur					Arund		
· ·	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last 87	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	8. Date of Birth (Month, Day 12/19/1	v. Year)	9. Birth	place (State of intry) NJ	or Foreign
-	3.5		Usual Residence of Decedent							12/13/1				
	d within 72 hours after death with the Maryland jiene. Ir than "natural", or iteme 23a or 28a-f ehow The Medical Examiner must be notified at	tor	MD 10a. State 10b. County Anne Arur	ndel	10c. City, T Sever		cation						10d. Inside C 1 ☐ Yes	
	or 28a	Director	10e. Street and Number		1		10f. Zip Code				10g. Citizen	of What Cou	untry?	
	23a c	ralD	792 Martin Court V				21144				USA			
Ω	after des	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1X Yes 2 \( \subseteq \)		1	Vas Decedent of H	an, Mexican	gin? (Spe , Puerto F	cify Yes or No- tican, etc.)	E	Race - Amer Black, White	, etc.	
2-0036	hours a	d by	3 ☐ Widowed 4 D\Divorced	If Yes, Give Year or Dates:	1		I ☐ Yes 2 ☐ No	Specify:				t Business/I		
-C12	within 72 ene. then "net	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	de <i>completed)</i> College (1-4or 5		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most	of working	g				
7	filed with Hygiene other the	Com	12	College (1940) 5	(**) C	Carpe	nter				Wood I		ng	
and	d la b	To Be	17. Father's Name (First, Middle, Last) Hyman Abramowitz							(First, Middle, enermar		iame)		
Mary	2 should be and Mental ie marked aumatic ev	-	19a. Informant's Name/Relationship (7	уре, Print)		19b. Mailin	g Address (Street	and Numbe	r or Rura	Route Numbe	er, City or To	wn, State, Z	ip Code)	
	and fealth m 27		Lee Allen				artin Ct. sition (Name of	. West	-	vern, I		44 on - City or T	Town State	
בסב	ages and of h		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		cemi	etery, cren	matory or other place Memorial P				Elkric			
altimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licen	see		22	. Name and Addre	ss of Facilit	y					
מ	<b>\$</b> ₽₹\$9		Hein Tim	) MO1			ary L. Ka 250 Wash					, MD'		10
			21a Part1. Enter the disease for company shock, or heart allure. List only of Immediate Cause (Final	one caus ron each lin	ne.	Do not ent	er the mode of dyli	ng, such as	cardiac oi	respiratory ai	rest,		Approxima Interval Be Onset and	tween
	Physician / /Medical		disease or condition resulting in death)	a Jue to (or as	a consequen	nce of):					_	-	5 yen	)
	Examiner	L	Sequentially list conditions,	b		an all							- 3	
<u></u>	uted 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Disa to (or as:	a sumancusan	ica ory:								
O O	certificate be executed nding physicien and use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequen	nce of):								
98/60,	icate b physic s the b	dlcai		d										1000
POX 6	eath certific attending p I for use as 1	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnanc	и				Date of deli		
o.	O O O	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)					Month	Day	Year
J	law requires that the de as been signed by the a 2 should be detached t	by Ph	Part II. Other significant conditions of	ontributing to death be	ut not resultir	ng in the u	nderlying cause giv	ven in Part I.		23e. Did t	obacco use c	ontribute to	the cause of	death?
ecords,	w require been sig should b									10	Yes 2ДN	<b>3</b> □ Pro	obably 4 [	Unknown
Ž	The law rate has be	Completed								24a. Was autor perfo		4b. Were au prior to d death?	topsy findings completion of	available cause of
Vital		0	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2710	1 🗌 Yes	20 No	
ot o	Phyeicli this cer al direct	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2□£R	VOutpatier	it 3□ DOA Ott	ner i	rsing Hor		dence 6 🗆	Other (Spec	cify)	
	ng l	ion:	27. Mann 1 Death  1 Natural 5 Pending  2 Assident investigation	28a. Date of Inju (Month, Day	y Year) 28	Bb. Time of Injury	Wo	nyat rk? ∣Yes 2.∐		28d. Describe l	how injury oc	curred		
DIVISION	Attendi er death. ector: A by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At home	e, farm, str	eet, factory, office	1700 2.0	_	28f. Location (: City or To		umber or Ru	ıral Route Nui	nber,
בֿ	ital or A			building, etc										
	To the Hospital or within 24 hours after To the Funarei Director Completely filled in b	Medical		ysician: To the best of niner: On the basis of and manner sta	f examination									s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	110	1		29c. Licens	se number	~ (e)	/	29d. Date si	gned (Monti	Day, Year)	
)			- Wear	Jula				200	099	Consultation of the last of th	101	24	OF	
	2		30. Name and address of person who	completed cause of d	eath (Item 23		Print)	will	. <i>()</i> ,	neve. C	rten	Bulni	e Ad	2106
100	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur		0-0-		- 1				7	/
	Regist	ar	OCT 2.4	1007 Bleece	en a Di	Kar.	1200ED							

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 26 AM **Physician** OcTOBER ACKERMANN 13 2007 JOSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Country) **Funeral** 1 ₹ M 2 □ F 595-15-2875 09/20/1991 FL16 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo M Anne Arundel Glen Burnie Director I 2 should be filed within 72 hours after death with the I h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-raumatic event, the Medical Examiner must be notifi 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 511 Burton Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No 3altimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) High School Student 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Lisa Bradfield Tyson Ackermann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Heatth ar
Important: If item 27 is
any Injury or other trau 511 Burton Road, Glen Burnie, MD 21061 Tyson Ackermann Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 10/19/2007 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cry I. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licenses M01378 Approximate Interval Between Onset and Death 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC /Medical Due to (or as a consequence of) Examiner RESPIRA TORY MAILURE EPSIS Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner THERMAL law requires that the death certificate be executed burial-transi INJUR COMPLICATIONS and Due to (or as a consequence of) attending physician for use as the hurial Box 68760 SURFACE AREA BURN Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 3d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.0. ed by the a 9 T Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? the Hospital or Attending Physician: The 2 □ No 2 🗆 No Yes certificate | 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28d. Describe how injury occurred DECEASED WAS TRYING TO BURN 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation MKNOWY W 1 ☐ Yes 2 ☑ 1 🗖 1 WASTE PRODUCTS 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after death.

I Director: / Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 511 BURTON ED. GLENDUANIE, MD 2106/ HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October, 13,2007 RES 000 M. AL-Zoubaidi

5

State Registrar MOHAMMED AL-ZOUS AIDI 31. Date filed (Month, Day, Year) 32. Re OCT 2 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Repistrar's Signature

4940 EASTEON AVENE BAITIMORE, MY 21224

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Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 9:10 P M 21, 2007 Oct. Carl Norman Brooks, Sr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center For Hospice Towson If Under 24 Hrs. 8. Date of Birth 11.06.1940 9. Birthplace (State or Foreign MD untry) 5. Social Security Number **39 212.38.49 67** 7. Age (In yrs. last birthday) Days Hours **Funeral** Months 1**X**M 2□ F 66 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Yes 2 No Harford Abingdon Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or U.S.A. 21009 605 Milford Ct. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

15. Yes 2 No It. Yes, Give Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Armored Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manone. Express Truck Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Elizabeth Walter Luther Wesley Brooks, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 605 Milford Ct. Abingdon, MD 21009 Arlene Brooks/Wife Vet0.24.07 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Owings Mills, 20a. Method of Disposition 1 ☐ 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto Alternatives 8717 Green Pastures Dr. MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** UN disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E.n.a. Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 N 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Hospital or Attending Prys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifie 25 205 N. Chales St. Balto-ald 21 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Bonc 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar Silver & DHMH 17 Rev 1/2001

		-	For State of Mar   State Registrar		artment of He rtificate of De		ental Hygi	g. N2 0 0 7	34043	
Ŧ			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death	
	Physicia /Medic		Dan Brown, Jr.					20, 2007	12:40P M	
	Examin	4 6	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
		200	The Johns Hopkins Hospital			Baltimore				
	Funeral		5. Social Security Number 6. Sex 7. Age ( 1 □XM 2 □ F	In yrs. last birthday Yrs.		If Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>		nplace (State or Foreign untry)	
	Director		261-44-4487	4			April 14	1,1933 FIC	rida	
	and w		Usual Residence of Decedent           10a. State         10b. County         1	0c. City, Town or L	ocation				10d. Inside City Limits	
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	ms 2.	Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14. Race - Ame Black, White		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 □ Never Married 2 □ Married 1 □ Xyes 2 □ No 1 □ Xyes 2 □ No 1 □ Xyes 2 □ No 1 □ Yes, Give Year or Dates:			Specify:	r nour, oto.	Specify	Lack	
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0	Ment Ment arked	흔	Dan Brown, Sr.			Mabel	Alber			
Mal	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mai	ling Address (Street an					
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Dallimor	permit Depar Impor any In once.		21. Signature of Funeral Service Licensee		<sup>22.</sup> Name and Address Donaldson F L411 Annapo	lis_Road	l Odento	on, Maryla	P.A. nd 21113	
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	p #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	consequence of):						
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Ö	ding Phys h. After this funeral di	11	27. Manner of Death 28a. Date of Injury	y 28b. Time	of 28c. Injury			ow injury occurred		
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5	tal or s afte al Dir ed in	Certification:								
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier  (Check only one)  1   Certifying Physician: To the basis of and manner state on the basis of and the basis of an and manner state on the basis of the basi	examination and/or	eath occurred at the tim investigation, in my op	e, date and place pinion, death occu	, and due to the or rred at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)	
	o the o the	Mec	29b. Signature and title of certifier		29c. License	number	- 2	29d. Date signed (Mon	th, Day, Year)	
	ک≒۶۲		Matalin Mr. Bonn	^	RES	000		October 2	0. 2007	
	- 1 r		30. Name and address of person who completed cause of de	ath (Item 23a) (Tvr		000		OCCUBEL 2	0, 2007	
	10+1				fe Street	Baltimo:	re, Mary	land 21287		
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature		-				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State No Mary And De Bart Henre 872 lebuth 24 ho Me Wal Hygiene Certificate of Death Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** PAMUEL 2007 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE **EDGEMERE** 2711 SPARROWS PT. ROAD Birthplace (State or Foreign Country) f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**X**M 2□ F Months Hours 216-12-6365 09-23-1922 NC Director 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 23a or 28a-f show ust be notified at BALTIMORE 1XYes 2□No MD **EDGEMERE** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be other traumatic event, 2711 SPARROWS PT. ROAD 21219 USA Funeral death v 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1944–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) MAIL SORTER PUBLICATION CENTER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be SAMUEL T. BOYD COLA BRANCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVA MAE BOYD/WIFE 2711 SPARROWS PT. ROAD, EDGEMERE, MD 21219 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 10/25/ Garrison Forest 10/25/07 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS FH, INC Sign tur Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 ames Anti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 07 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injurthat initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes No 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes No. 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Di completely filled in Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ow M.D 10 N. Green St Balt 2120

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** $\mathbf{P}^{\mathsf{M}}$ Fred C. Barantas 19, 2007 Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Fallston Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 219-22-7533 Director 78 15,1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Edgewood 1 ☐ Yes 2 X No Harford MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ö 57 Little Creek Lane 21040 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: þ White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Publisher Computer Operator injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Barantas Mary Girulis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bowers- Stepdaugther 235 Cams Fortune Way Harrington, DE 19952 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10/26/07 Baltimore, MD 4 Donation 1 5 ☐ Other (Specify) 21. Sign ure of F nera Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. any 6415 Belair Rd Baltimore, MD 21206 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DNEUMONIA days **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner OBSTEUCTIVE monary disease HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as e consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 11) Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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To the Funeral Director: After

28a-f show

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items 23a

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permit. Pages 1 and 2 should be filed: Department of Health and Mental Hygis Important: If item 27 Is marked other:

10/19/07 152Baltimore, Maryland 21215-00

4 | Homicide

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

OCT 2 4

29a. Certifier

determined

and manner stated.

1308

32 Registrar's Signature

30. Name and address of person who comple

Medical

State

DHMH 17 Rev 1/2001

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Way

29d, Date signed (Month, Day, Year)

2007

State of Maryland / Department of Health and Mental Hygiene 17

		For State Registrar	State of Maryland	/ Depa	artment of H	lealth and Death		ene2 0	07	34046
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/Medic	al -	WILLIAM			4b. City, Town, or			4c. County		
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tificate g phys as the			.u					100		
ding se a	Physician/Med	IF FEMALE:	23c. If yes, outcome pf pregnar	псу				23d. D	ate of deliv	ery
attendin for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		□Ectopic pregnance □ Other (specify) _	:у		, N	/lonth	Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
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ires t	b	A 77 77 6	este des-				1 🗆 Y	′es 2 No	3∏ Pro	bably 4 Unknown
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nysic lis ce direc	.0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E		aur all boy		ing Home 5 ☐ Resid			ify)
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nding ath. r; Afte e fune	읉	1 Natural 5 Pending 2 Accident investigatio				]Yes 2□No	•			
Atte r deg ecto	ij.	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, s	treet, factory, office	)	28f. Location (S City or Tox	Street and Nui vn. State)	mber or Ru	ral Route Number,
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spita rours nera		29a. Certifier 1 Certifying P	nysician: To the best of my know	wledge, dea	ath occurred at the	time, date and	place, and due to the	cause(s) and	manner as	stated.
To the Hospital or within 24 hours afte Fo the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exa	miner: On the basis of examinat and manner stated.	ion and/or	investigation, in my	opinion, death	occurred at the time,	иате апа ріас	e, and dde	to the cause(s)
ormpl	Me	29b. Signature and title of certifier			29c. Licer	se number		29d. Date sig	ned (Month	, Day, Year)
<b>⊢ ≶ ⊢</b> ō		Daws 3				37755		O.T.	hom 3	4 2007
		30. Name and address of person who		23a\ (Tue-		32295		- 1 -	10KL	1,000
11			15 W. MACPHAIL			E 106	- BEL AI	R, MD.	2101	L4
7		DAVID DUNN - 6	32. Registrar's Signar		0011			•		
Sta	ate	OCT 9 / 201	7	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Рм 1:25 10 21 2007 Barbara Daggett Corrsin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Brightwood Center Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-25-1922 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔀 F 85 California 572-26-2129 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No MD Baltimore Riderwood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Trappe Lane 21139 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Eliot Daggett Mary Arnold Shanklin ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Corrsin/Daughter <u> 1206 Trappe Lane, Riderwood, MD</u> 21139 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service
Corporation 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 10-24-2007 21. Signature Anneral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arterioscheidic **Physician** YB /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient ၉ 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: the

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565N. Chayles St Suite 209

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 19 2007 10:30pm Louise V Carter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Baltimore Oak Crest Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M Yrs. Woodstock, VA 224 22 8209 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Kingsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or idical Examiner must be 21087 USA 11873 Stoney Batter Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Interportant: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Blue Cross Blue Shield N/A Supervisor-Claims 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Wisman Golda Hottle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12321 Stoney Batter Rd Kingsville, Md. 21087 Rebecca Nash (Daughter) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc October 22 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Funeral Service Licensee 22. Name and Address of Facility EF Lassahn Funeral Home PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac errespiratory arrest, larged the Court (First). Immediate Cause (Final disease or condition resulting in death) End Stage **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical aftending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 □ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MIN, hyperlipidemia, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ischemic affacts certificate has b irector, page 2 sl autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide in 24 hou. the Funeral Dirr 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

To the F

complete 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/20/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud, Parkylle, MD 21234 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 4 2007 Registrar

S.P. 16:30 Pm

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			1- State Registrar	of Maryland /4	Department of He Certificate of De	<b>all</b> h and Mental Hy e <i>ath</i>	giene Reg. No.2007	34049
	Physici	an	1. Decedent's Name (First, Middle, Last)	111		2. Date of De Month		(3) Time of Death
	*/Medic	al	4a.)Facility Name (If not institution, give street and	number)	4b. City, Town, or Lo	ocation of Death	4c. County of Dear	1 12:03 M
	LAGIIIII	*	Mercy medic		irthday) If Under 1 Year	MUCE f Under 24 Hrs. 8. Date of Bir	th O Bird	ibulana (Ctata au Faurian
* *	Funeral Director		5. Social Security Number 1 6 Sex 1 M 2 F	7. Age (In yrs. last bit		Hours Min. (Month, Date of Bill	ay, Year)	thplace <i>(State or Foreign</i> puntry) ROVIA <b>,</b> LIBERIA
App	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Location			10d. Inside City Limits
	a-f sho	ctor	MD PRINCE GEORGE	's BO	WIE			1 Yes 2 No
	n with the	al Director	10e. Street and Number 3400 NOTTINGHILL CT		10f. Zip Code 29716		10g. Citizen of What Co UNITED STAT	
36	be filed within 72 hours after death with the Maryland thal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. Forces? s 2 \ No Give r Dates:		anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:		
21215-0036	within 72 hou ene. <b>than "natur</b> a ne Medical E	Completed		16a e (1-4or 5+) 6 <b>Yrs</b>	a. Decedent's Usual Occupatio (Give kind of work done dur life. DO NOT use retired)	on ing most of working ADMINISTRATOR	16b. Kind of Business.  BUSINES	·
nd 2	al Hygi other	Be Co	17. Father's Name (First, Middle, Last)	5115	1/	8. Mother's Name (First, Middle	, Maiden Surname)	
Maryland	Mer Mer arke	P P	SAMUEL F. VOKER  19a. Informant's Name/Relationship (Type. Print)	191	h Mailing Address (Street and	PAPAH GAYE  d Number or Rural Route Numb	ner City or Town State	Zin Code)
	nd 2 salth ar 27 is r trau		HENRY CLEMENT/EX SPOUSE	1	,	L CT., BOWIE,		
Baltimore,	# <b>#</b> # #		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro	om State cemete	of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or	
altim			4 □ Dorjation 5 □ Other (Specify)  21. Sig lature f Funeral Servi e license	F/T. L:	INCOLN CEMETER 22. Name and Address		BRENTWOOD,  MORTUARY	MD.
Ä	permit. Departr Importa any ing	4	Ham Johns	on fall	<u> </u>	ND AVE., N.E. V	· · · · · · · · · · · · · · · · · · ·	
	Physician		23a. Part1. Enter the disease of complications the shock, or heart failure. List only one cause of limmediate Cause (Final disease or condition resulting in death)	at caused the death. Do n each line.		such as cardiac or respiratory a		Approximate Interval Between Onset and Death
	/Medical Examiner		Mo Due	t or as a con equence	of):			J
7	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or s a consequence	of):			
> '09	icate be executed physician and s the burial-transit	I Examiner	that initiated events c	to (or as a consequence	of):			
68760,	phy:	edica	d					
O. Box	The law requires that the death certificate has been signed by the attending agge 2 should be detached for use as	Physician/Medical	in the past 12 months?	outcome pf pregnancy ve birth 2 ☐ Fetal deatl egnant at time of death iknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
ds, P.0	ires that t signed by I be detac	þ	Part II: Other significant conditions contributing to	death but not resulting i	in the underlying cause given		tobacco use contribute t	
Records,	tw require s been sign should b	Completed				24a. Was	s an 24b. Were a	utopsy findings available
I Re		Comp				auto perf 1 Yes	ormed prior to death? 2 No 1 □ Yes	completion of cause of s 2 🙀 No
Vital	sician: certific rector,	o Be	25.)Was case referration medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) Hospital:	rpatient 2 ER/O	Othor	26. Place of Death (Check only  4 □ Nursing Home 5 □ Res		noife)
0	ng ffer iner	$\Gamma = 1$	27. Manner of Death 28a. Da (Natural 5 Pending (Natural 5 Pending (Natural Pending Pending (Natural Pending Pending (Natural Pending Pending (Natural Pending Pe	ate of Injury 28b.	Time of 28c. Injury a linjury Work?		how injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of injury - At home, falliding, etc. (Specify)	arm, street, factory, office	28f, Location	(Street and Number or Flown, State)	ural Route Number,
_	Hospital 24 hours Funeral etely filled	Medical Co	(Check only 2 Medical Examiner: On the			, date and place, and due to the nion, death occurred at the time		
	To the within To the Comple	Me	(29b. Signature and title of certifier	Shaw		10 NPT 13 12 533	29d. Date signed (Mon	oth, Day, Year)
	H		30. Name and address of person who completed of		(Type, Print)			
	Sta	ate	BILL SHAW MD. 301 ST.  31. Date filed (Month, Day, Year) (33)	PAUL PL.,	DALTIMORE, MI	). ZIZUZ		
	Regist		OCT 2 4 2007	Dodger &	Branke			

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Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17. 2007 Joseph Harper Craven October 6:50 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Howard Scaggsville Road Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 1 M 2 □ F 88 29, 1918 Washington, 577-09-4798 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. Stete 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Maryland Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 10369 Scaggsville Road 20724 Funerai 12. Wes Decedent Ever in U,S. Armed Forces?

1 (X) Yes 2 □ No If Yes, Give Yeer or Dates 12 − 45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify. þ 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Telephone Installation & Repairman Bell Atlantic Telephone Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Leo Α. Craven Lillian G. Harper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3513 Rolland Ave, Baltimore, MD 21211 Matthew Craven- son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/20/07 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home, INC. M01234 7601 Sandy Spring Rd, Laurel, MD 20707 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury Box 68760, by Physician/Medicai thet initieted events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 100 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Certification: To 1 🗌 Yes Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? within 24 hours after deeth.

To the Funeral Director; After completely filled in by the fun 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one)

State Registra

31. Dete filed (Month, Day, Year) 2007

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29b. Signature englititle of certifier

32. Registrer's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Kevin Cullen-MD22 S.Greene St., Baltimore, Maryland

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34052 Reg. NZ U U 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Cantrell 4:00 AM 10 10 2007 Orothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Med Ctr Glen Burnie Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 K F Months Days Hours Min. Director 10/27/1940 220-36-0880 66 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Invariant or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 252 8th Street 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural"; or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Cashier State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett Entsminger ပ Sylvia Mathney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Davis / Daughter 103 Willowbrook Drive, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veteran's Cem 10/23/07 Crownsville, MD 21. Signature of Emeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Actoriosclembe disease or condition resulting in death) 100 ms /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 1 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 40 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 2 R/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) >1966 10-18-2007

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brothy

State Registrar

(income) 31. Date filed (Month, Day, Year)



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Leecoutz do)

2007

2-toline

\$508. Colon Borney Manyland 21066

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 0611 Christine Dombrowski 10-20-2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months Min. 1 □ M 2 🕅 F 220-52-2743 83 07-13-1924 Germany Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2316 Perry Ave 21040 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johunn Hulbig Else Morgenroth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Dombrowski (Son) 507 Pearwood Dr Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lutheran Cem. 10-22-2007 Joppa, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MECHANICAL DISSOCIATION disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) HONIC KIDNER IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes → No 24a. Was an autopsy Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Unpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Examiner and attending physician for use as the buria the or Vital Records, has this certificate

P.O. Box 68760.

**Division** 

death.

within 24 hours after death To the Funeral Director:

the Hospital

CHRISTINE

DOMBROWSK

Physician

/Medical

Examiner

**Funeral** 

Director

Items 23a or 28a-f show Examiner must be notified at

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if item 27 is marked other than "natural", or other traumatic event, the Medical Exa

ould be

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

Funeral

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Physician/Medical ģ Completed Be P funeral Certification: filled in by the

25. Was case referred examiner?	
27. Manner of Death	
Natural	5 Pending investigation
2 Accident	investigation
3 ☐ Suicide	6 Could not be

determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	(Check only
	one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DRIVE, SUME 21,

29d. Date signed (Month, Day, Year)

State

Medical

30. Name and address of person who completed cause of Dr ANNSHA - SIM TAALA

3. Registrar's Signature T 2 4 2007

Registrar

07-08103

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Frank Dewitt Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day October 17, 2007 1642 hrs Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYY g. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Wany lan Months Days Hours Director 215-86-8471 -25-196 1 4 M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 1 Yes 2 No 28a-f show notified at once. u pmore A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. ST 21213 23a Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Never Married 1 L Yes 9 f Yes. Give Year Specify: Blac Widowed Divorce Yes 2 No specify: ant of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural",
other traumatic event, the Medical Examiner. à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 MD 21215-0036 pto/09151 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Lashle 19a. Inform t's Name/Relationship (Type, rint) 19b. Mailing Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code) B4/b. mother Mura 15sac 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Ballo Nationa Donation 5 Other Specify: Name and Address of Facility Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line een Onset and /Medical Death a. Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury mai initiated Due to (or as a consequence of): events resulting in death) Last and A Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -X UNPENDED AMEAUSED, 27, perME, g872, 10/25/07 IT 11 per wife g875 1-10-08 vt Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death past 12 months' Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has be director, page 2 sh performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 2 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 X Natural Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 18, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD . Registrar's Signature 31. Date filed (Month, Day, Year) State Registra 2007 **ÓRIGINAL** OCME

DHMH 17 Rev 1/2001 **OCMF 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NIEL 22 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner V ALTIMORE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M M 2 ☐ F **Funeral** Director January ennsy Venia Usual Residence of Decedent 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Director S Dury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. I health and Mental Hygiene than "natural", or Items 23a or Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 1 orther traumatic event, the Medical Examiner must be 1 owlar 12. Was Decedent Ever in U.S. Armed Forces! 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (174or 5+) Specialist nstruments Hea 18. Mother's Name First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be Lran 19b. Mailing Address (Street and Number or Beral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Twife 4781 Meadowlark MD urante 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It any injury or o once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 21216 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Gneet and Death Severe Immediate Cause (Final Physician Anemia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): physician a the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: A
rilled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the

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State Registrar

MOCK 31. Date filed (Month, Day, Year) OCT 2 4 2007

29b. Signature and title of certifier

THE JOHNS HOPKINS HOSPITAL, 600 North WOIFE Street, BALTIMURE, MAKYLAND 21287 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL DOCTOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07942 State of Maryland / Department of Health and Mental Hygiene William Edward Daniels 34056 Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 11, 2007 1640 hrs William Edward Daniels Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3900 W. Cold Spring Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year Age (In yrs. last birthday) 5. Social Security Numberunk 6. Sex **Funeral** Min. Months Days Hours Country) Maryland Apr 30, 1953 Director 54 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 Yes 2 No Baltimore 23a or 28a-f show notified at once. with the Maryland 10g. Citizen of What Country rector 10f. Zip Code 10e. Street and Number 21215 ۵ 3900 W. Cold Spring Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **23**a 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: black Yes 2 X No specify: f Yes, Give Year permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in injury or other traumatic event. 3 Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 11 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Daniels edward Daniels Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ို Baltimore, MD <u>516 Manchester Avenue Baltimore,</u> MDVan Daniels/cousin Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in 22. Name and Address of Facility 21. Signature of Funeral Strvice License Ronald S. V 655 W. Baltimore Street State Anatomy Board Baltimore, MD 2120 Wade rector Approximate Interval that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Pak I. Enter the disea Between Onset and **Physician** failule. List only one cause on each line Death Maditta Narcotic intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical X UNPENDED AMENDED, 27, 28a-f, perME, g872, 10/26/07 TT attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown s been signed by the should be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ö Yes 2 No 3 Probably 4 ✔ Unknown þ Records. P. 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? certificate has 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital r Attending Physician: within 24 hours a ter ceath. 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: ER/Outpatient 3 Inpatient 2 this 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: 1 Yes 2 X No Natura Pending Fnd 10/11/2007 Fnd 4:30p.m. Oirector: din by the f 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 6 X Could not be Suicide 3900 W. Cold Spring Lane Baltimore. MD determined (Specify) To the Funeral I Found at home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

30. Name and address of pers

31. Date filed (Month, Day, Year)

Jack Titus MD.

n who completed cause of death (Item 23a)

32. Registrar's Signature

Deputy Chief Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 12, 2007

State of Maryland / Department of Health and Mental Hygier 34057 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0ct 17 11:00 a M Jamie Dean 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods Nursing Home Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F Yrs. Director 218-09-0550 87 \$ept 26,1920 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits I7 is marked other than "natural", or Iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Overlea 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4705 Meise Drive 21206 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐ Yes 2☐ No Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other my injury or other traumatic event. 9DE8. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Welsh Elsie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4705 Meise Drive Baltimore, MD 21206 Michael Kenney - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/22/07 Baltimore, MD 4 □ Denation 5 □ Other (Specify) Metro 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Faneral 6415 Belair Rd Baltimore, MD 21206 Pirt1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or he or failure. List only one cause on each line. Approximate Interval Between Onset and Death Implediate ar se (Final lisease or condition resulting in death) **Physician** AIM926 /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any teacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of The faw requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical use as the IF FEMALE: 23c. ff yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performed? certificete 2 \ No 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Pface of Death | Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: or Attending Injury 1 Naturaf 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the th within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D53462 MD and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ROAD Glen Burnie 2481 OAKWOOD MD 21061 sude Muneres Registrar's Signature 31. Date filed (Month, Day, Year) State 28000 24 2007 OCT 13 600 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** SANDRA OCTOBER 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 220-54-5179 58 MD Director APR. 28,1949 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2115 E. NORTH AVE. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 🗷 No <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 Is marked other the any Injury or other traumath. 12TH BUS AIDE EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lafayette Boone YVONNE FIELDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 WOODBOURNE AVE., YVONNE FIELDS BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5712 O DONNELL ST. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/22/2007BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FH 2007-09 EASTERN AVE., BALTIMORE, 23a. Part1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** failure 2 weeks /Medical Due to (or as a consequence of) Examiner Alcoholic cirrhosis 5 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine certificate be executed and Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe certificate | 1□ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 🔚 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760 P.O. Records, Division or Vital

Baltimore, Maryland 21215-0036

the 2

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIONA HAVERS, JOHN'S HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE MARYIAND 21287
31. Date filed (Month, Day, Year)
32. Pagistrar's Signature

Tions Howers, MEDICAL DOCTOR

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

OCTOBER 13, 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:20 AMM October 19, 2007 Ruth Fischer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Morningside Assisted Living Prince Georges Laurel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
NY Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Days 1 □ M 2 🕽 F 96 03/07/1911 Director 090-01-1800 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State iral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 □ No Directo Laurel MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707-USA 7700 Cherry Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 □ Divorced Year or Dates "natural" Completed er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the Mone. Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Lippman Tobias Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Woodside Parkway Silver Spring, MD 20910-Nora Kisch/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 10/20/2007 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer i Sewice Licen. 22. Name and Address of Facility
Rapp Funeral & Cremation Services States Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KRULL /Medical Due to (or as a consequence of): Examiner rendiovanoular disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (New 23a) (Type, Print)

Marie Dobyns 7380 Ver

State Registrar 31. Date filed (Month, Day, Year,

2 4 2007

32 Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

10

State

10724 477LE PATOKUNT PKWY COWMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

O. MYANISM

OCT 2 4 2007

DAVID

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 22, 2007 GOLDIE 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) '. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Director 06/17/1907 <u>212-52-8859</u> 100 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SUDBROOK LANE 21208 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify: WHITE þ 3 Widowed 4 □ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MICHAEL HELLER IDA UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 SALONY DRIVE #105 - REISTERSTOWN, MD 21136 ARNOLD C. FINE / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition PETACH" TIKVAH "CONG". 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final THEROSCHEROTIC EREBRO VASCULAR DISEAT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending property for use as as 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Donknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 211No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 ☐ 1 No ို 1 🔲 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours after death.

To the Funeral Director; After Hospital

> State Registrar

DHMH 17 Rev 1/2001

ASNEEM 31. Date filed (Month, Day, Year)

OCT 2 4 2007

29b. Signature and title of certifier

KHAN! 2835 SMITH 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

HVEI SUITE

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	ryland	/ Depa	artment of H rtificate of L	lealth Deat	and Me h		giene Reg. No		34062
	Physicia	an	1. Decedent's Name (First, Middle, L	asi)	100		-			2. Date of De Month	ath Da	y <sub>,</sub> Year	3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution, g	ive street and number)	1125		4b_City, Town, or	Locatio	n of Death	10	40	County of Dea	0770
	Examin	er	Onchorage	Nursina	Ref	ab	Salish	Uri	1 ME			1 1 1	nico
	Funeral		,	Sex 7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	Min.	8. Date of Bir (Month, Da Jan 2,	v. Year)	9. Bir	thplace (State or Foreign ountry) X.a.S
	Director		579-42-0816 Usual Residence of Decedent		75					Jan 2,	193	2 16	
	anylan	_	10a. State 10b. County			Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	ecto	MD WIcomic  10e. Streel and Number	0	S	alisb	10f. Zip Code				10a. Cit	tizen of What C	
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	ems 2	Iner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic (	Origin? (Specan, Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi	
36	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-f ehow ha Madical Examiner maal bu notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		lo		1 ☐ Yes 2 ☒ No	Speci				Specify: W	nite
2-00	2 hour	ted k	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation	act of working		16b. K	(ind of Business	/Industry
218	ithin 7	nple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done o	during III	OSLOL WORK	19		1	1
d 21	Hygier Hygier other ti	e Col	10 17. Father's Name (First, Middle, La	0 st)		boo	okkeeper	18. Mo	ther's Name	(First, Middle			pply company
lan	Mentel Kentel rkad o	To Be	Leon Powell							Brown			
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Exeminer transit by inciting at once.		19a. Informant's Name/Relationship Claudia Cooper/o				ng Address (Street a						Zip Code)
Baltimore,			20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Oher (Spe		cer	ice of Dispo metery, crei	osition (Name of matory or other place	ce)	D.	ate	20c. L	ocation - City o	r Town, State
Balti	permit. Departmimports any inju		21. Signature of Euneral Service Lice Round of Science 1	wade bir	ctor		Name and Address ate Anato altimore,	_	Board 21201		Ва	ltimore	Street
6			23a. Part . Enter the disease, or co shock or heart failure. List on	implications that caused by one cause on each lin	the death. ne.				as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	IAVE								
В	Examiner			Due to (or as	a conseque	ence of):							
	n =	ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	1 Contectue		-2-11	. 1					
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque		orillAT	ON					
8760,	icate be executed physician and s the burial-transit	dlcal E		d	a 001100q0	3.100 017.							
9	rtificati ng phy as the	Medic	IF FEMALE:										
О. Вох	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[	∃Ectopic pregnancy ∃ Other (specify)	/				23d. Date of de Month	elivery Day Year
<u>α</u>	w requires that the state of the signed by should be detact	d by Ph	Part II. Other significant condition	s contributing to death b	ut not resul	ting in the u	inderlying cause giv	en in Pa	irt I.		tobacco Yes 2		to the cause of death? Probably 4 Dunknown
of Vital Records,	The law reste has bee page 2 sho	complete								24a. Was auto perf 1 Yes		prior to death?	autopsy findings available completion of cause of
/ita	Physician: this certificant	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ace of Death	(Check only	one)	-12	
of	Physical direction	1: To	1 Yes 2 No 27. May er of Death	28a. Date of Inju		R/Outpatie 28b. Time o		W		ne 5 ☐ Res 28d. Describe		6 □Other (Sp ury occurred	ecity)
ion	Attending or death.	atlor	Natural 5 Pending 2 Accident investiga		y Year)	Injury		k? Yes 2	□No			,	
Division	of or Atte	Certification:	3 Suicide 6 Could no determin		ury - At hon c. (Specify)	me, farm, st	reet, factory, office		1	28f. Location City or To	(Street a	und Number or F te)	Rural Route Number,
-	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Diractor: After this certificete ha completely filled in by the funeral director, page	edical C		Physician: To the best aminer: On the basis of and manner sta	examination								
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licens	dmun e	er		29d. D	ale signed (Moi	nth, Day, Year)
			) AND.	MY			163	42	3		10	114/7	
			30. Name and address of person w	106 M	UFO 1	an s	丁 好 切	43	, MD	21804			
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2	32. Registr	ar's Signati	ure,	Garles						

			For State	State of Mary		artment of H			giene Reg. No 2007	34063
			Registrar  1. Decedent's Name (First, Middle, Last)			Timodio or i		2. Date of Dea		3. Time of Death
	Physicia		LUCILLE GRIGGS					Octobe	Day Yea	67 8:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of De	
/	LAAIIIII	C1	UNION MEMORIAL	HOSPITAL		BALTI	MORE			
	Funeral		Social Security Number 6. Sex	7. Age (Ir	yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h 9. B	irthplace (State or Foreign Country)
	Director		212-22-7394	M 2⊠F	79 Yrs.	Monato Baye	110010	JAN. 1		MD
	pur »		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	faryla sho ed at	ō								1 XYes 2 No
	the N 28a-1 notifi	Director	MD 10e. Street and Number	Į.	BALTIMO	10f. Zip Code			10g. Citizen of What	Country?
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at			777		21212			USA	•
	ns 23 mus	Funeral	4725 IVANHOE A	2. Was Decedent Ever	r in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
	r Iter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		If Yes, specify Cuba		o Rican, etc.)	Black, Wi	
<u> </u>	ral", o Exan	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: D	Bilok
215-0036	be filed within 72 hours after death with the Marylar d tall tygiene. d other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	edent's Usual Occup	during most of wor	king I	16b. Kind of Busines	ss/Industry
7	filed within 72 Hygiene. other than "na ott, the Medic	Jdu.	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	•		0.77.1771	OMERIC
2	led w lygiel her ti nt, th		12TH 17. Father's Name (First, Middle, Last)		\$1	LVER DE	-	ne (First Middle	SILVEI  Maiden Surname)	R SMITH
anc		Be						io (i not, middio,	maidon dariamo,	
Maryland	d 2 should th and Men 77 is marke traumatic	ပ္	JOHN H. McCRAY  19a, Informant's Name/Relationship (Type	ne. Print)	19b. Mail	ina Address (Street	ANNIE and Number or Ru	ıral Route Numbe	er, City or Town, State	. Zip Code)
<u>8</u>	h h h		GARY GOODWIN/N	,		D. BOX 4			-	203
ā,	- I 5 =		20a. Method of Disposition		20b. Place of Disp		1	Date	20c. Location - City	
e E	e = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•		i i	2/20070	OWINGS MI	TLLS MD
altimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	e all	1 2	22. Name and Addre	ss of Facility W.F.	SLEY C	HAVIS, JI	R. FH
n	o a L o		Allsley	Mars		2007-09	EASTER	N AVE.	. BALTIMO	DRE, MD
П			23a. Part1. Enter the disease or complishock, or heart failure. List only on	rrest,	Approximate Interval Between					
	Physician		Immediate Cause (Final disease or condition		e Se					Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence of):				et .	10
	Examiner	_	Se uentially list conditions,	DISSE	minadea	d Intrav	asculor	Coagul	ation	Une day
	ed	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ì	. ,					11 - 1000 110
	xecut and	Examiner	that initiated events resulting in death) Last	Due to (or as a co	n phoma onsequence of):					Unknoon
8760,	ficate be execute physician and is the burial-trans	dical E	d							
89	ificate g phy as the	edic								
ŏ	Jeath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome pf p 1 ☐ Live birth 2 [		□Ectopic pregnanc	,		23d. Date of	•
Box .	deat le atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tim		Other (specify)			Month	Day Year
Vital Records, P.O	w requires that the d been signed by the should be detached	hyę	9 ☐ Unknown					00 5:11		- A- 4b
Ś	res th igned be de	by	Part II. Other significant conditions con	eiutus eiutus	ot resulting in the	underlying cause giv	en in Paπ I.			e to the cause of death?  Probably 4 100nknown
oro	requi	ted	piabetes in	elajas					1es 2 No 3	Probably 4 Polikilowii
ec	e law nasb	Completed						24a. Was autoj	psy prior	autopsy findings available to completion of cause of
<u></u>	t The	S						1 es	ormed? death 2 No 1 Y	
<u> </u>	'sician: The law s certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	lospital:		ort 30 DOA Oth	or.	ath (Check only o		
ō	Phys r this ral dii	- To	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpatie	SIK SELDON	4 🗆 Nursing r		dence 6 Other (S how injury occurred	pecify)
on	ding P h. After t funera	tion	1 V Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	of 28c. Inju Woi M 1 □	·ḱ? Yes 2 □ No			
Division or	I or Attend after death. Director: /	fica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	- At home, farm, s	treet, factory, office		28f. Location (	Street and Number or	Rural Route Number,
	al or safter	Certification:	4   Horricide	building, etc. (	Specify)			City or To	wii, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			sician: To the best of n						
	To the H within 24 To the F complete	Medical	one)	and manner stated						
	5 W. 5	2	29b. Signature and title of certifier	1. 00	0	29c. Licens		28	29d. Date signed (M	
)				KAR, M			M 3891			14,2007
F	) '		30. Name and address of person who co	impleted cause of deat	n (item 23a) (Type	F MOVELAL	HOSPITA	L 201 F	E. UNIVERSY	H PKWY, BALILL
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	12 M #	1		,	MV Z
	Regist		OCT 2 4 200	7 Bless	13. 19	341		1		M PKWY, BABY

State of Maryland / Department of Health and Mental Hygien 2007 34064 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2007 Jr. Edmond Phillip Garrett 12:40 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooklyn Park 5331 Wasena Avenue Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Feb 18, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1953 10 M 2□ F Maryland Yrs 216-60-8845 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Marylend and Mental Hygiene.
Is marked other than "netural", or Items 23e or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Item 27 is marked other than "netural", or Items 23e or 28a-1 show other treumstic event, the Neulcal Examination matter at Brooklyn Park Md. Anne Arundel Co. 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 5331 Wasena Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 E Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self-employed Roofer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Garrett Sr. Barbara Higginbotham Edmond Phillip 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent; If Item 27 Is n eny Injury or other treun once. Mary Gardner, companion Balto. Md. 5331 Wasena Ave. 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/23/07 Baltimore, Md. Bayview Crematory `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GONCE Funeral Service P.A. 4001 Ritchie Hgwy. balto. Md. manualistic Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Lung **Physician** Verrdisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To the funeral 27. Manner of Death
1. Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Handres St BLHOIMD 3001 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4 2007

			For State Registrar	State of Mary	land / D	epartment of H Certificate of I	lealth and Death		giene2007	34065
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ith	3. Time of Death
	Physici /Medio		Robert W. Gibson	ı				October	12, 2007	7:18 PM M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h	4c. County of De	ath
			Atlantic General			Berlin			Worces	
	Funeral		5. Social Security Number 6. S	M 2□F	yrs. last birtl	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	9. B	inthplace (State or Foreign Country)
	Director		577-36-9970 Usual Residence of Decedent	7	<u>/</u> '	13.		June 2,	1930 Was	hington DC
	Maryland -f ahow		10a. State 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
	r 28a-f ahow	tor	DE Sussex		Selbyv	ville				1 Yes 2 No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
01	deeth with the ms 23a or 28s [.mast be not	rai	33 E. Law Point				19975		USA	
523		nue	11, Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, lite, etc.
2 7 28	urs after decal, or items	by Funeral Director	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: 140	0 50	1 ☐ Yes 2Д No	Specify:		Specify: W	hite
5-003	within 72 hours after ene. then "netural", or Ite he Medical Examina	ed	15. Decedent's Ed	ducation	16a.	Decedent's Usual Occup	ation		16b. Kind of Busines	s/Industry unk
272	nin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)		(Give kind of work done d life. DO NOT use retired	during most of wo d)	rking		,
21.5	a filed within Hygiene. other then	E O	12	2		club r	nanager			
o o pue	be filed withing the hygiene. It other then event, the h	Be (	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
<u>a</u>	2 should be n and Mental is marked o	၉	Wilton Brown Gi					Eliz Ove		
O G	and 2 sh salth and n 27 is m sr traum		19a. Informant's Name/Relationship ( Natalie Gibson/		19b. 33	Mailing Address (Street: E. Law Poin	and Number or R nt Road	ural Route Numbe Selbyvil	r, City or Town, State 1e, DE 199	75
DOB - DOB - Baltimore, Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☒ Donation 5 ☐ Other (Specification)	Removal from State	Ob. Place of cemetery	Disposition (Name of c, crematory or other place	ca)	Date	20c. Location - City	or Town, State
Ball	permit Depart Import any in		21. Signatur Ronald Servic Licer	Wade Virec	tor	State Anat Baltimore,	-		Baltimore	Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do n	ot enter the mode of dyin	ig, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. live	r Ca	mcer				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence d	f):				1
		er	Sequentially list conditions,	b. Due to for as a go	rsamance o	n.				
	uted Insit	min	cause. Enter Underlying Cause (Disease or injury that initiated events			.,				
ď	icate be executed physicien and s the burial-transit	Examin	resulting in death) Last	Due to (or as a co	nsequence o	f):				
68760,	cate be ohysicie the bur	dicai		_ d						
			IF FEMALE:							
550n Box	The law requires that the death certificate has been signed by the attending cage 2 should be datached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of o	lelivery Day Year
11/20	es that igned to be date	by P	Part II. Other significant conditions of	contributing to death but no	ot resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ore	equire en sig ould b	edt	Coroning	Artery	Dis	erse	<del> </del>	101	res 2□No 3□	Probably 4 Donknown
Becco €	The law requ	Completed						24a. Was autor perio 1 Yes	nsy prior t med? death	autopsy findings available o completion of cause of
isal †		BeC	25. Was case referred to medical examiner?				26. Place of De	ath Check only o		20110
ber TVIE	Physic this ce al dire	To	1 Yes 2 TNo	Hospital: 1 ☐ Inpatient	2 ER/Out		4 🗀 Murshing	Home 5 ☐ Resid	dence 6 Other (S)	pecify)
SN20			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. T	ijury Wor		28d. Describe I	now injury occurred	
Sign	Attendidenth death ctor: A	cat	2 Accident investigatio 3 Suicide 6 Could not b		At home for		Yes 2 ☐ No	206 Leasting /	Parant and Mumber of	Curat Courte Museum
Sivision	7 9 7 6	Certification:	4 Homicide determined	building, etc. (S	Specify)	m, street, factory, office		City or To	Street and Number or vn, State)	nurar noute ryumber,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of m niner: On the basis of exa and manner stated.	amination and	, death occurred at the tir for investigation, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To t To t	2	29b. Signature and title of certifier	6		29c. Licens	367	83	29d. Date signed (Mo	onth, Day, Year)
				completed cause of death		Type, Print) Athunts	- Gener	al Hosi	ritul Ber	In und
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2 4 200	32. Registrar's	0:	hall				
_		_								

07-08149 Quraan Holloway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	Regis	trar		Certiii	cate of De	auı		Pos No	200	77 210
Physiciar cal Examin	n/ <sup>1. De</sup>	Cedent's Name (First, Midd	dle,Last)	1.0			2. Date of Month	Reg. No. Death	Year	3. Time of Death
		acility Name (if not institution	on, give street and num	DAY per)	4b. Cit	y, Town, or Location of	Octobe	r 19, 2007		0935 hrs
	S	inai Hospital				timore	Deali	46. 0	County of Deat	n
Funeral Director	5. Soc	cial Security Number	i	Age (In yrs. last bi		nder 1 Year If Under		Birth(MM/DE		rthplace (State or
5.100101	216	-21-1378	1 M 2 F	19	Yrs. Mo	nths Days Hours	Min. Sector	embos 1	Forei	THARY And
any	10a. S	Residence of Decedent tate 10b. County		10c. City, Tow	m or Location		Ospic	inger 7	7	
<b>*</b>	= Has	uland H	A	0 1						10d. Inside City Limit
Tied within 72 hours after death with the Maryland Hygerthan do ther than "natural", or items 23a or 28a-f she other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Firmeral Discrete		reet and Number	, ,	SHITI	nole 10f. 2	Zip Code		10a Citizer	n of What Cou	
ith the Maryland  23a or 28a-f sho notified at once		07 Park HE	Eight Tone	Ace.		21215		/	154	na y :
tems 2		rital Status Never Married 2 M	12. Was Deced	ent Ever in U.S.	13. Was Dece	dent of Hispanic Origin	? ( Specify Yes or	No- 14		ican Indian, Black,
", or i			1 Yes	2 X No	1	cify Cuban, Mexican, P	uerto Rican, etc.)	4	White, etc.	Amazani
atural"	45 5	ecedent's Education (Spe	an Dutani	completed) . 16a.		2. No specify:	d of work days	S	ecity:	TITIERICIAN
led within 72 hour tygiene. other than "nate the Medical Exar	Eler	nentary/Secondary (0-12)	College (1-4		during most of w	orking life. DO NOT us	a of work done e retired)	16b. Kind	d of Business/	ndustry
led within 7 Hygiene. other than the Medical		10 24			Stude	ent				
uld be filed with Mental Hygiene. marked other tl r event, the Med		her's Name (First, Middle,	-			18.Mother's I	lame (First, Middi		rname)	
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2 sh an 27 i ma	190	landa Bel			11 000 1	Signal Street and Number			or Town, State	, Zip Code)
s I and of Healtl If item her trau		ethod of Disposition  Burial 2 Cremation		20b. Place	of Disposition (Na	ame of cemetery.	/ ERRA		ation - City or	Town, State
nent o ant: or oth		Donation 5 Other Sp	3 Removal from	State	tory or other plac	e) .	1/	1/	1.	m /
permit. Fag Department Important: injury or ot		nature of Funeral Service	Licensee		22 Name an	d Address of Facility	GORR 302	20 KAM	sobune	MARGIOR
	230 Pr	ucy m.	Malla	e.	3405 E	d Address of Facility m. WALLACE D. Franklin	Street -	Baltim	ore MAR	land 2122
ysician ledical	fai	rt I. Enter to disease, or dure. List only one cause of	complications that cause	ed the death. Do no	of enter the mode	of dying such as good	ac or reeniratory	rrest shock	or Heart	Approximate Interva
			on odon mio.				ac or respiratory a	most, shock,	or rieart	
aminer	Immedi or cond	ate Cause (Final disease ition resulting in death)	a. Gunshot wour	ds (2) to torso			uo or respiratory a	mest, snock,	orneart	
aminer	or cond	ate Cause (Final disease ition resulting in death)	on odon mio.	ds (2) to torso			ac or respiratory a		or neart	Between Onset and
	or cond	ate Cause (Final disease ition resulting in death) tially list conditions, eading to immediate Enter Underlying Cause	a. Gunshot wour  Due to (or as a con b.  Due to (or as a con	nds (2) to torso			ac or respiratory a	mest, shock,	or neart	Between Onset and
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 4:00 A M **Physician** HODKINS 18 2007 October Stanley Charles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air MD Harford Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F Maryland 04/18/1918 Director 213-12-0863 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Bradshaw Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21087 U.S.A. 8009 Dowell Lane Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify. White S02543 43 /0//8/ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced "naturaf", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be fill d within 72 l Department of Health and Mential Higiene. Important: If item 27 is marked other than "nati any injury or other traumatic even, the Medica (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Edgewood Arsenal Equipment Specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisye Belle Coale Harry Nelson Hopkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1203 Glenview Court - Churchville, Maryland 21028 Mary D. Bogan (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gds.10/23/2007 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 00 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Iweek Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and is the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 ☐ Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' Yes 2 No Division or Vital 26. Place of Death (Check only one, director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 **□**No 1 Inpatient 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ie Hospital or Attendi 24 hours after death. ie Funeral Director: A 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 18, 2007 D53186 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +1 615 W. MacPhail Rd, Ste. 100 Bel Aig, MO21014

State Registrar

31. Date filed (Month, Day, Year)

Juice

mid TIMBEY 32. Registrar's Signature

enny Ray Harm		State of Maryland / Department of Health and M	lental Hy	giene				
	F	1- For State Certificate of Death Registrar		Reg	o. No. 20	3 Time of Death		
Physicia ledical Examir		1. Decedent's Name (First, Middle, Last)		Month Day Year 0755 hrs				
		Kenny Ray Harmon  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local	ation of Death	00.000.720	4c. County of De	ath		
		12328 Pulaski Highway Joppa			Baltimore C			
Funeral		or decidir decidiriy realization	F Under 24Hrs. Hours Min.	-	(MM/DD/YYYY) 9.	eign		
Director		214.86.1081 XM 2 F 35 Yrs. Months Days F	TIOUIS IVIIII.	02.09	.19/2	Country) N.C.		
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits		
A		MD Baltimore Middle River				1 Yes 2 No		
faryland 28a-f show	Director	10e. Street and Number 10f. Zip Code	-	10	g. Citizen of What C	ountry?		
n the Maryland 3a or 28a-f sho otified at once.	ă	9729 Matzon Road 21220		1	U.S.A.			
with ms 23	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic			14. Race - An White, etc	nerican Indian, Black,		
or ite	Fu	1 Yes 2 No		1 (1001), 0(0.)		White		
s after	ā	or Dates:	Give kind of w	vork done	Specify: 16b. Kind of Busine	ss/Industry		
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5+)						
5-0036 led within 7 Hygiene. other than the Medica	Completed	9 Brick Cleane	r		Commerc	ial		
5-0 led wi Hygie other					faiden Surname)	-		
D 21215-003 should be filed within and Mental Hygiene. T is marked other that	Be	Howell B. Harmon, Sr. F.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and			1 Abbott			
, MD 21215-0036 and 2 should be filed within 72 hours afte teath and Mental Hygiene. ten 27 is marked other than "natural", traumatic event, the Medical Examiner	٩	Frances Oppel/Mother   8 Alder Driv						
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter		Date	20c. Location - City			
nore		1 Burial 2 Cremation 3 Removal from State Chesapeake Crem.	10	.24.07	Beltsvi	11e, MD		
Baltimore, permit Pages I an Department of Her Important: If ite	1	4 Donation 5 Other Specify:  2 Signature of Funeral Service Licensee  22. Name and Address of F	Facility Cr	ematio	n And Fu	neral Balto		
E Pe E	2.0	Alternativ				res Dr. MD		
Physician Medical	. ,	23a. Pargl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	ch as cardiac o	r respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death		
xaminer	3 9	Immediate Cause (Final disease or condition resulting in death)  a. Fentanyl intoxication  Due to (or as a consequence of):				300		
	Ш	Sequentially list conditions, b						
	iner	If any, leading to immediate Due to (or as a consequence of):						
7=	Examin	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
be executed ician and urial - transi		0.						
	edical	AMENDED #23a, PII. 27, 28a-f, perME, g873, 11/9/0	07 TT		23d. Date of deli	very		
876 tificat ing ph	J/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 E	Ectopic pregna	ancy	Month	Day Year		
Box 68760 e death certificate b the attending physical	sicis	1 Yes 2 No 9 Unknown 9 Unknown			0			
D. B.	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?		
P.O. es that the igned by	þ	Coccino vao		1 Yes	s 2 No 3	Probably 4 🗸 Unknown		
ords, P.(  **requires that  s been signed  should be det	etec			24a. Was autop		e autopsy findings available to completion of cause of		
Records, P.O. Box 68760.  The law requires that the death certificate cate has been signed by the attending phyapage 2 should be detached for use as the b	Completed				rmed? deat			
of Vi ling Physi After this funeral dir	n: T	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at			how injury occurred			
ivisior or Attend after death Director:	catic	Pending   Fnd 10.20.2007 unk   1 Yes   Accident   Accident   Investigation   Property   Accident   Property   Property   Accident   Property   Property	ding etc	unk	Street and Number of	r Rural Route Number City		
Divi	Natural  Accident  Accident  Accident  Substitute  Accident  Accident  Substitute  Accident  Acc							
lospit 4 hour Tunera		798. Cettillet   a us t me t t m t t t t t t t t t t t t t t	and place, and	d due to the caus	se(s) and manner as	stated.		
o the lithin 2 o the l	Medical	(Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the line, date a me one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	eath occurred	at the time, date	and place, and due	to the cause(s)		
E § E 8	Me					(Month, Day, Year)		
l'a		latin O.C.M.E	E.		October 21, 2	2007		
O Kneed		30. Name and address of person who completed cause of death (tuem 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimo	ore MD 21	1201	· · · · · · · · · · · · · · · · · · ·			
1 1		Designation Signature						
5	tate	31. Date filed (Month, Day, Year)						

State of Maryland / Department of Health and Mental Hygiene 0 0 7 34069 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 15, 2007 **Physician** 2258 Be11 Henson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 63 Yrs. 8. Date of Birth (Month, Day, Year) Apr. 28, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1□M 2፟MF Yrs. 579-56-5792 New York Director 1944 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Hyattsville 10a. State 10b. County 10d. Inside City Limits Show r than "natural", or itema 23a or 28a-f sho tra Medical Examiner must be notified at Prince Georges Md. 1X Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 20785 7405 Greeley Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT, use retired)
Teacher's Aide 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DC Public Schools Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Bell Daisy Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is rother tra Columbia, S.C. 29209 (Son) 8100 Garners Ferry Rd. Sharif Parker Henson 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State = 0 permit. Page Department o Important: if any injury or once. Oct. 20,2007Washington, D./C Glenwood Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 20010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventricular Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any second to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consouence of Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit idena' Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for L 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificete X No 1 Yes 2 🔀 No 1 Tyes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes PNo Impatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sanfurazi M.D 10 hammud 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Sarfara3i 1 tunover 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

		1	For	ertificate of Death	Reg	3. No.2007 34070	
	Decedent's Name (First, Middle, Last)  Physician				2. Date of Death Month	Day Year	
	Physician Cayetano Ibanez			1		21, 2007 9:30P M	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Anne Arundel	
	-		Baltimore Washington Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda)	Glen Burnie  (i) If Under 1 Year   If Under 24 Hrs.			
	Funeral Director		5. Social Security Number  5. Social Security Number  1. Age (in yis. add buttles)  1. Age (in yis. add buttles)  Yrs.  Usual Residence of Decedent	Months Days Hours Min.	(Month, Day, Aug 30,	Year) 9. Birthplace (State or Foreign Country) Puerto Rico	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at	or	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	the M	Directo	Maryland Anne Arundel Sever	10f. Zip Code	10	g. Citizen of What Country?	
	with a or			21144		United States	
	heath ns 23 mus	Funeral	7718 Locust Wood Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
10	r iter	Ē	1 Never Married 2 Married   Armed Forces? 1 1 Yes 2 X No   If Yes, Give	· M· · · · · · · · · · · · · · · · · ·			
93	urs a	by	3 XWidowed 4 ☐ Divorced Year or Dates:	Pue	erto Rica	II WIIICC	
2-0	72 ho natui ilcal	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	king 1	6b. Kind of Business/Industry	
7	ithin and and and and and and and and and an	Jdu.	Elementary/Secondary (0-12) College (1-4or 5+)			Airlines	
2	led w tygies her tl nt, th		12th PO	osta1/Baggage	ne (First, Middle, M		
anc	t be find the find th	Be		Amalia	Bou		
ž	hould d Me mark matic	욘		iling Address (Street and Number or Ru	ıral Route Number,	City or Town, State, Zip Code)	
Ma	nd 2 s Ith an 27 Is trau			B Locust Wood Road	Severn,	Maryland 21144	
<u>6</u>	tem tem		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)		20c. Location - City or Town, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notifiled at ance.		1 □ Burial 2 Wicremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify) W. Aruno	del Crematory 10/	23/2007	Odenton, Maryland	
Bal	permit Depar Impor any in		Quanta (R Thomas	22. Name and Address of Facility Donaldson Funeral 1411 Annapolis Roa	d Odento	on, Maryland 21113	
8			23a. Part Enter the disease, or complications that caused the death. Do not a shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est, Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition a Metastatic Pro-			Onser and Board	
4	/Medical		resulting in death)  Due to (or as a consequence of):				
B	Examiner		Sequentially list conditions, b. Sepsis				
	B/ #	ine	Sequentially list conditions, if any, leading to immediate cause. E.ite. Underlying Cause (Disease or injury that initiated events				
	an an-trans	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):				
60,	be e) ician buria						
68760,	ificate be executed y physician an as the burial-transit	edical	d				
Box	ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year		
P.0	ires that the de signed by the be detached t		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?	
or Vital Records,	signe d be	d by			1 □ Ye	es 2 No 3 Probabły 4 Xunknown	
Sor	w require been si should b	Completed			24a. Was a	n 24b. Were autopsy findings available	
Re	The law	gu			autops	med? death?	
8			25. Was case referred to medical	26. Place of De	1 Yes : ath (Check only on	21	
5	Physiclan: this certificated ral director,	o Be	examiner? 1 ☐ Yes 2 ☐ No  Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpa	Othor		ence 6 Other (Specify)	
		1: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe ho	ow injury occurred	
ion		ië	Matural 5 □ Pending (Month, Day Year) 11,00 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	i ji fe o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	treet and Number or Rural Route Number, n, State)	
1	To the Hospital or Attend within 24 hours after death To the Funeral Director. completely filled in by the	ical C	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and placer investigation, in my opinion, death occ	e, and due to the courred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)	
	To the within 2 To the complet	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	
			1 Decla	000 65 703		October 21, 2007	
	10		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		Burnie, Maryland 21060	
	,		Dr. Berhane, M.D. Baltimore Washir  31. Date filed (Month, Day, Year)  32. Degistrar's Signature		er ATGH	Duline, Haryrand 21000	
	Regist	ate trar	OCT 2 4 2007	Specific			

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State of State of Registrar	Maryland / Dep <i>Ce</i>	ertificate of L		ental Hygler Reg.	2007	34071
			. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al	Robert Lamonte Joyce	<u> </u>					
5	Examin		a. Facility Name (If not institution, give street and numb Saint Joseph Medica	l Center	4b. City, Town, or	Location of Death Tows C		4c. County of Deat Bal	imore
. 5.00	Funeral		6. Sex 7.	Age (In yrs. last birthda) Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co.	nplace (State or Foreign untry)
	Director	-	212-30-6836  Jsual Residence of Decedent	74			4/29/19	933   MD	
	land ow	- H	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	a-fsh ified	ţċ	MD Baltimore	Baldwi	n				1 ☐ Yes 2 No
	th the or 284 e not	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
	ath wi	<u>ra</u>	6238 Windy Ridge Rd.		21013			ited St	
	er dei items ner m	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Deced Armed Force 1 □ Never Married 2 ☑ Married		B. Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White	
5	be filed within 72 hours after death with the Marylan Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Dat	es: Korea	1 ☐ Yes 2 💢 No	Specify:		Specify:	hite
Maryland 21215-0036	72 hou natura ical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occup we kind of work done o DO NOT use retired	ation during most of work		o. Kind of Business/	Industry
21	ithin 7 le. " nan "1	현	Elementary/Secondary (0-12) College (1-4	lor 5+)				74040 06	: MD
7	filed w Hygier Sther then the		172 17. Father's Name (First, Middle, Last)	18	ix assess		e (First, Middle, Mai	State of den Surname)	_MD
anc	should be filed id Mental Hygi marked other matic event, ti	Be c				Fdi+h	Dawson		
2	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  In marked other than "natural" or items 23a or 28a-f show In marked other than "natural" or items 24a or 28a-f show Inmatic event, the Medical Examiner must be notified at	ဍ	Robert Joyce  19a. Informant's Name/Relationship (Type. Print)	19b. Ma	uiling Address (Street	and Number or Rur	al Route Number, C	ity or Town, State, 2	Zip Code)
Š	alth a alth a 27 is		Margaret Joyce / wi	Fe 623	88 Windy	Ridge R	d. Baldw	in, MD	21013
Zre,	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from S	20b. Place of Dis	position (Name of rematory or other plac	ce)	Date 200	c. Location - City or	
Ĕ	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)	Chesar	eake Cre				e,Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		Du da Xuo Kallu	M0143	22. Name and Addre C. remation 8717 Gi	and Fun een Pas	eral Alte	rnatives ve Baltin	nere, 190 21214
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do not och line.	enter the mode of dyir	ng, such as cardiac	or respiratory arrest	1	Approximate Interval Between Onset and Death
	Physician		a.	NARY ARTE	RY DISEA	SE			
	/Medical Examiner		resulting in death)  Due to (c	r as a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate b. Due to (c	r as a consequence of):					
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
ó	e exec an an irial-tr	Exa	resulting in death) Last Due to (c	or as a consequence of):					
8760,	icate be executed physician and s the burial-transit	dical	d						
မ	leath certific attending p I for use as	/Me	IF FEMALE: 23c. If yes, outc	ome pf pregnancy				23d. Date of de	elivery
Box	atten atten	Physician/Me	in the past 12 months? 4 Pregna	ant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	·y		Month	Day Year
o.	t the c by the achec	hysi	9 ☐ Unknown			_			as the assume of dooth?
ls, P	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	by	Part II. Other significant conditions contributing to de	ath but not resulting in th	e underlying cause gi	ven in Part I.	23e. Did toba 1 ☐ Yes		o the cause of death?  Probably 4 Unknown
Records,	requi	Completed					24a. Was an	24b. Were a	autopsy findings available
Rec	e la has	I du					autopsy performe		
E			25. Was case referred to medical			26. Place of Dea	th (Check only one)		
or Vital	Physician: r this certific ral director,	To Be	examiner?	npatient 2 ER/Outpa	ttient 3 DOA Ot	her: 4 🗆 Nursing H	ome 5 Residen	ce 6 □Other (Sp	ecify)
0 0	ng Ph fter th neral		27. Manner of Death 1	of Injury 28b. Tim h, Day Year) Inju	ry Wo		28d. Describe how	injury occurred	
Siol	Attending r death. ector: After by the fune	catic	2 ☐ Accident investigation	of injury - At home, farm		Yes 2 No	28f. Location (Stre	et and Number or I	Rural Route Number,
Division	or At after d Direct in by	Certification:	determined   200, Flace	ng, etc. (Specify)	, street, factory, office		City or Town,	State)	
_	spital ours a peral filled	edical Ce	29a. Certifier  (Check only (Check only and mean	asis of examination and/	leath occurred at the or investigation, in my	time, date and place opinion, death occi	e, and due to the cau urred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the Hos within 24 hd To the Fur completely	Medi	29b. Signature and title of certifier	ner stated.	29c. Licen	se number	290	d. Date signed (Mo	nth, Day, Year)
	Z X Z 00		Mul Cum	in W	р39	215		10/19/0	7
	11.1		30. Name an oddress of person who completed rau	e of death (Item 23a) (Ty	/pe, Print)			1	
L	41		GAIL CUNNINGHAM M.		SLER DRIV	E TOWSC	IN, MARYI	_AND 218	2014
	Si Regis	ate	31. Date filed (Month, Day, Year) 32. F	pistrar's Signature	Prout I				

DHMH 17 Rev 1/2001

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bert Jackson		State of Maryland / Department of Health and Men	ital Hygiene	2007 34072				
		Registrar Servindate or Death	Reg. N	No. 3. Time of Death				
Physicia		Decedent's Name (First, Middle, Last)	Month Da October 14, 2					
edical Examii		ROBEL C SUCKSON		4c. County of Death				
		- Ad I delity reality	or Dealin	Anne Arundel				
		occi e daticioni e dedi.	ler 24Hrs. 8. Date of Birth(N	//////////////////////////////////////				
Funeral	- 1	Months   Davis   Hour	s Min.	Foreign				
Director		527-44-7077 1X M 2 F 68 Yrs. Months Days House	June 2, 1	939 Country) Texas				
		Usual Residence of Decedent		10d. Inside City Limits				
w an		10a. State 10b. County 10c. City, Town or Location		1 Yes 2 X No				
and show	5	Maryland Anne Arundel Laurel						
re Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?				
ith the Maryland 23a or 28a-f sho notified at once		3334 Sudlersville South 20724	US	5A				
ath with the items 23a ust be not	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical		14. Race - American Indian, Black, White, etc.				
death or ite	Ĕ	1 Never Married 2 Married 1 X Yes 2 No		Mile & A				
after al", c	by	Wildowed 4 Divolced in 165 Civil 1841 59-62 1 165 2 166 Speciny		ареалу.				
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	호[	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give during most of working life. DO NO		6b. Kind of Business/Industry				
36 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)						
within ene.	Ĕ	2 Lawn Technician	La Alama (First Maiddle Mari	Vector				
			er's Name (First, Middle, Mai	den Surname)				
2121 old be fil Mental F marked c event,	8	THE TATH COURSE	ia Marsh	City or Town State Zin Code)				
more, MD 21 Pages I and 2 should nent of Health and Me ant: If item 27 is ma	의	19a. Informant's Name/Relationship (Type, Print )  Maxine Jackson- wife  19b. Mailing Address (Street and Nu 3334 Sudlersville Sou						
and 2 shou lealth and 1 tem 27 is r traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		Oc. Location - City or Town, State				
S la of He of He	H	1 Burial 2 X Cremation 3 Removal from State crematory or other place)		·				
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic		4 Donation 5 Other Specify: Metropolitan Crematory		Mexandria, Virginia				
talt rmit. eparte inport	. 1	21. Signature of Funeral Service Licensee  22. Name and Address of Facil Fleck Funeral Hom	ity ne, INC.					
E.E.A.B.III		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	r Road. Laurel. N	1D 20707 shock, or heart Approximate Interval				
Physician /Medical		failure. List only one cause on each line.	cardiac or respiratory arrest	Between Onset and Death				
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  or condition resulting in death)		Death				
		or condition resulting in death)  Due to (or as a consequence of):						
	-a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	듩	ause. Litter Underlying Cause  Disease or injury that initiated  C.  Disease or injury that initiated  Disease or injury that initiated						
J. B. isi	Examiner	events resulting in death) Last  Due to (or as a consequence of):						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	ical							
O, e be er rsiciar burial	edic	UNPENDED AMENDED		23d. Date of delivery				
376 ficate g phy s the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ector	pic pregnancy	Month Day Year				
K 68	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		2				
Bo; deat the at	ηs	1 Yes 2 No 9 Unknown g Unknown						
that the d	by P			acco use contribute to the cause of death?  2 ✔ No 3 Probably 4 Unknown				
Vital Records, P.O. hysician: The law requires that th this certificate has been signed by I director, page 2 should be detach	q p							
rds v requ	ompleted		24a. Was an autopsy	prior to completion of cause of				
ecc he lav ite ha	m Z		perform 1 ✓ Yes 2	ed? death? No 1 ✓ Yes 2 No				
I R m: T rtiffica for, p	S	25. Was case referred to medical 26.Place of Deal	th (Check only one)					
of Vital Recling Physician: The After this certificate funeral director, page	o Be		Nursing Home 5 Re	esidence 6 🗸 Other: Scene				
of ing Ph.	-	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c, Injury at Wo	ork? 28d. Describe ho	w injury occurred				
On endir ath. or: A	텵	1 Valural 5 Pending	No					
ivision or Atteno after death Director:	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building,	etc. 28f. Location (Str or Town, Sta	eet and Number or Rural Route Number, City				
Divisior pital or Attencours after death teral Director: filled in by the								
Hosy 24 ho Func stely f	alC		place, and due to the cause(	s) and manner as stated.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death and manner stated.						
- s + s	ž			29d. Date signed (Month, Day, Year)				
. 11		O.C.M.E.		October 15, 2007				
641		30. Name and addr / of per on who completed cause of death (Item 23a)	(					
OCME		Mary G. Ricole MD. Deputy Chief Medical Examiner 111 Penn Street, Balti	more, MD 21201					
	tate	1 1 1 7 /1 /1111 / POTA POT 21 - A - ACT D						
Regis	trar	TO I WILL COOL WARRINGS IN THE PROPERTY OF THE PARTY OF T						

			State of Maryland / Description	epartment of Health and Mental Hygiene Certificate of Death Reg. 2007 34073
	Physici /Medic		1. Decedent's Name (First, Middle, Last) John Charles James Jr.	2. Date of Death October 17, 2007 3. Time of Death 11:36 A M
all a	Examin		4a. Facility Name (If not institution, give street and number)  Johns Hopkins Bayview	4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N/A
	Funeral Director		5. Social Security Number 217-18-5282  Usual Residence of Decedent  6. Sex 1 1 1 M 2 F 7. Age (In yrs. last birthe 83 Yr.	Months Days Hours Min (Month Day Year) Country)
	Maryland a-f show filed at	tor	10a. State 10b. County 10c. City, Town of Md . N/A Balti	1 DVan 2 DNa
	th with the 23a or 28a	al Director	10e. Street and Number 6143 Cardiff Ave.	10f. Zip Code 10g. Citizen of What Country? U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat he notified at once.	by Funeral	11. Marital Status  1 □ Never Married  2 ◯ Married  1 □ Never Married  2 ◯ Married  1 □ Never Married  2 ◯ Married  1 □ Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	(Specify only highest grade completed) (()  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working ite. DO NOT use retired)  Pervisor  Steel Company
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) John James	18. Mother's Name (First, Middle, Maiden Sumame)  Ada Unknown
	and 2 sho ealth and N n 27 Is ma	'	Edna James/WIFE 61	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Cardiff Ave., Baltimore, Maryland 21224
Baltimore,	t. Pages 1 tment of H riant: If ite		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar 4 ☐ Donation 5 ☐ Other (Specify)	Disposition (Name of crematory or other place) Hill Cemetery  10/20/2007  Date 4444  20c. Location - City or Town, State Baltimore, Maryland
Ba	Permi Depa Impo any ii		23a. Part1. Enter the disease, or complete s that caused the death. Do no shock, or heart failure. List only one cause on the line.	22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Ave., Baltiore, Maryland 21224 It enter the mode of dying, such as cardiac or respiratory arrest.  Approximate
8760,	Physician /Medical Examiner und physician un	lical Examiner	shock, or heart fayore Lateronly one cause of line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  C. Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)  C. Due to (or as a consequence of)  Due to (or as a consequence of)  Due to (or as a consequence of)	ic cuman arten disease
P.O. Box 6	ath certific titending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
	w requires that the de been signed by the a should be detached f	ρ	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 □ Yes No 3 □ Probably 4 □ Unknown
Il Records,	The law requivate hes been page 2 should	Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) Yes 2 \( \text{Yes} \)
Vita	sicien: certific irector.	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only one)
Division of Vital	nding Physicien: The ath. r. After this certificate he funeral director, page	ation; To	1  Yes 2  O	me of 28c. Injury at 28d. Describe how injury occurred
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director; / completely filled in by the f	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the fir, e. date and plane, and due to the cause(s) end in an ren as stated or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c. License number  29d. Date signed (Month, Day, Year)
)	5 × 5 0	_	29b. Signature and title of official and the second who completed cause of death (flow 23a) (T	041399 10/18/07
7	-0		30. Name and address of person who completed cause of death (Item 23a) (Theodore A Sighless MO	
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 2 4 2007  32 Registrar's Signature	Garle

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34074 Certificate of Death 4b. City, Town, or Locetion of Death | Solution | April | Apr 1. Decedent's Name (First, Middle, Lest) one 00 a., Facility Name (If not institution, give street and number) HCK Manor 5. Social Security Number ursing Home 7. Age (In yrs. last birthday) Yrs. If Under 1 Year 6. Sex, 1 ☑ M 2 ☐ F Days Months 26-5615 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Kesvi Mary land 10e. Street and Number, 10g. Citizen of What Country? 10f. Zip Code 2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1□ Yes 2 No Blac Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) astor 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) ones dale VIODI rober 19a. Informant's Name/Relationship (Type, Print) ( Wite) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State Zip Code) 4 Khell Road Mrs. Rubye 20b. Place of Disposition (Name of cemetery, crematory or other place) Pikes Ville, MD 21 20c. Location - City or Town, State MD 21208 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 0 29 07 Maryland Memorial rbutus 4 ☐ Donation 5 ☐ Other (Specify) 22 Name end Address of Fecility JOSEPH L. RUSS 2222 W. North 21. Signature wureral Service Licensee Home, P.A. Funer AVL. uneral Balton, MD 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Multiple Myelomo Immediate Cause (Final disease or condition resulting in death) Years Due to (of as a consequence of) Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of deeth? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Tunknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital:

**Physician** /Medical Examiner

been signed by the ettending physician and should be deteched for use as the burial-transit

After this certificate has

Be

Certification:

Medical

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a, State

Director

Funeral

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Completed

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.Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show vary injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated events resulting in death) Last à Completed

25. Wes case referred to medical examiner? 1 ☐ Yes → No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: Sursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie person who completed cause of death (Item 23e) (Type, Print)

29c. License number D0061199 29d. Date signed (Month, Day, Year) QT, 21,200 7

Ø

State Registrar 31. Date filed (Month, Day, Year) 24

Black



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

07-07784 Taukii Jordan

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2007 34075

00,42		1- For State				(	Certifica	ate of	Death					Reg. N	lo		3. Time of Death
Physicia		Registrar 1. Decedent's Name	e (First, Midd	le,Last)								2	. Date of D Month Octobe	eath Da	y Yea		1717 hrs
Exami		Taukii	Jorda	.n					b. City, Tov	- 0516	ention of		Octobe	5, 20	4c. County of	f Death	
		4a. Facility Name (i	f not institution	on, give stre	eet and nu	umber)		14	b. City, 10v Silver S		ocation or	Death			Montgon		
		12323 Juds	on Road								If I I adea	Odlies	R Date of	Rinth/N			hplace (State or
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In	yrs. Iast bir	thday)	If Under Months	Days	If Under Hours	Min.				FOLGIO	n
Director		220-96-4	154	1 X M	2 F		31	Yrs.	Monais	Days	Tiodio		Dec	25,	1975	Col	untryTexas
		Usual Residence of				L											10d. Inside City Limits
ny		10a. State	10b. County			10c.	City, Town	or Locati	on								1 Yes 2 N
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-f sh	ţ	10e. Street and Nu			<u> </u>				10f. Zip C	ode				10g.	Citizen of W		ntry?
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ms 2	Funeral	11. Marital Status  1 X Never Marr	ind 2	Married		Forces?	1 111 0.0.	If Y	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.	)	Whit	e, etc.	
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ould d Me s ma lic ev	2	19a. Informant's N													pe, MI		
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permit. Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other traumat	,	21. Signature of I	uneral Servi	ce License			ator	22.	Name and	Address	of Facilit	y Soar	d 655	W.	Balti	more	Street
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiera. Important: If item 27 is narked other than "natural", injury or other traumatic event, the Medical Examinezing or other traumatic event, the Medical Examinez.	•							100	1 + imc	ra	MIX	-2121	.) [				Approximate Inter
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Medica			only one cau	(	ardio	megaly								_			Death
Examine		Immediate Cause or condition resu				s a consequ	uence of):										
				b												_	
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Division of Vital Records, tal or Attending Physician: The law requir is after death.	ğ	w 25. Was case re	eferred to me								Ce of Dea Other		k only one		Residence	6 1 0	Other: Scene
/15a /sicia nis ce	direct	examiner?	2 No		ospital:	Inpatien	nt 2 E	R/Outpati	ent 3	DOA			sing Home				Aller, Scene
Of Ving Phy	funeral	27 Manner of [			28a.	Date of Injur Month, Day,Ye		8b. Time	of Injury		jury at W		28d. D	escribe	how injury o	curred	
Figure 1	e fun	5 1 X Natural	-	Pending		vio, = -,,	···			1_	Yes 2	No					
Arte r dear	by the	2 Accider	•	Investigation	28e.	Place of Inju	ury - At hon	ne, farm, s	street, facto	ry, office	e building	, etc.	28f. Lo	cation (	Street and N State)	umber c	or Rural Route Number
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Spite hours				na Dhueici			knowledne	e, death or	ccurred at t	he time,	date and	place, a	ind due to	the cau	se(s) and ma	nner as	stated.
DIVISION Of VITAL RECOURS, T.C. DOX OUT To the Inopinal or Attending Physician: The law requires that the death certificate by the attending Poly the attending To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director: After this certificate has been signed by the attending to the Funeral Director: After this certificate has been signed by the attending to the Funeral Director: After this certificate has been signed by the attending to the Funeral Director.	completely	(Check only one)	Medica	ng Pnysici Examiner	:On the b	asis of exan	nination and	d/or invest	tigation, in	my opin	ion, death	occurre	d at the tir	ne, date	and place, a	and due	to the cause(s)
To the Howithin 24 To the Fu	comp	0			and man	ner stated.			12	9c. Lice	ense numb	per			29d. Date	signed	(Month, Day, Year)
		29b. Signature	and title of C	Cruilei	111	ŧ D				0.0	C.M.E.				Octobe	er 6, 20	007
	-	MO	Mora	. The	yn	w											
	-	30. Name and	address of p	erson who	completed	d cause of d	eath (Item 2	23a)	1 Penn S	Stroot	Raltim	ore M	D 2120	1			
			a Korell N			Medical				meet,	Daluill	OI G, 1VI	2 2 120				
	St	ate 31. Date filed	Month, Day,	Year)	7	32. Registra	r's Signatur	e Apr	West !								
Po	gist	rar	OCT 2	4 2007	Sie	ALE PROPERTY	900	1									

State of Maryland / Department of Health and Mental Hygiene 007 34076 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:00 A October 18, 2007 Edward L. Kahler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital 8. Date of Birth (Month, Day, Year) Aug. 18,1913 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□F Yrs. Maryland 94 Director 216-07-9623 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23s or 286-f show other traumatic event, the Mudical Executer must be notified at 1 X Yes 2 No Directo Baltimore Maryland N/A 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number U. S. A. 21223 109 S. Amity Street by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is markad other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Wholesale Clerical 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Kilfoyle 2 Adam E. Kahler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8810 Walther Blvd, Apt 1502, Parkville, Md. 21234 Charles P. Kahler (Brother) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) o = 0 permit. Page Department 10/20/2007 Baltimore, Maryland Important: I any injury o once. Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Maryland 21236 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ongumonia Immediate Cause (Final disease or condition days **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760. physician Physician/Medical as the signed by the attending IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed UBBC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an A5600 has autopsy performed? 1 ☐ Yes 2 ☐ No 2 4 No WIL or Attending Physician: 26. Place of Death (Check onl. one Be 25. Was case referred to medical examiner? Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 HNatural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 31295 Klug mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendy Klocs

31. Date filed (Month Day) Nigha-us SI Sinte 4202 70 WSON Kloesz 6701 32. Registrar's Signature Maria. State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12:05 A<sup>M</sup> OCT 19 2007 LAURENCE C. KINDBOM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 23,1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 XM 2 ☐ F Massachusetts 73 006-30-0896 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21044 10476 Sternwheel Place 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Tyyes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Coast Guard Ret. Captain 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vida Gaetz Hilmer Kindbom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10476 Sternwheel Place Columbia, MD 21044 Catherine M. Kindbom (Wife) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Arithoton National 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-14-2008 Arlington, Virginia Cemetéry 21. Sign to 6 Funeral Service Licensee Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

sician and burial-trans ed by the attending physician detached for use as the buria After this certificate has been signed by funeral director, page 2 should be detach

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

124 hours after death. le Funeral Director; Alletely filled in by the fu within 24 hou

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completely fi

	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death							
	Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC LUNG  Due to (or as a consequence of):	CANCER		Silset and Dealin							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last	b			5.1							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy ner (specify)	2	23d. Date of delivery Month Day Year							
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the underlying cause given in Part I.  1   Yes   Variable   Yes   Variable   Variable											
complete				24a. Was an autopsy performed? 1∐ Yes 2∑ No	24b. Were autopsy findings availabl prior to completion of cause of death?  1 □ Yes 2 □ No							
Bec	25. Was case referred to medical		26. Place of Dea	ath (Check only one)								
0	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3	B DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6	3 □Other (Specify)							
ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred							
ertifica	3 ☐ Suicide 6 ☐ Could not be determined		factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )							
Medical Certification: To	29a. Certifier 1 Certifying P (Check only one) Medical Exa	Physician: To the best of my knowledge, death oc aminer: On the basis of examination and/or invest and manner stated.	curred at the time, date and place ligation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. I place, and due to the cause(s)							
ĕ	29b. Signature and title of certifler	D 11 11	29c. License number	29d. Dat	e signed (Month, Day, Year)							
	1 un	CHally M.D.	0101240449	(VA) 10	19 2007							

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State Registrar

2041

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSN

HOLLIS

JAMES R.

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend #30, perDVR, g872, 10/24/07 TF ertificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER **Physician** 2007 3:00 PM KLAVENS **ELMER** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 6311 GREENMEADOW PARKWAY BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/22/1911 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 95 MD 212-01-0383 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examples. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 U.S.A. 6311 GREENMEADOW PARKWAY Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Tes 2 No
If Yes, Give X
Year or Dates: 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 No Specify 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PHARMACY PHARMACIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KLAVENS IDA UNOBTAINABLE ၉ JULIUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6311 GREENMEADOW PARKWAY - BALTIMORE, MD 21209 CLAY C. CLAY / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date BACTIMORE HEBREW 10/24/2007 1 Burial 2 □ Cremation 3 □ Removal from State REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS. INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician ue to (r as a consequence ff): /Medical Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and ched for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has certificate 2 No 1 ☐ Yes 2□ No Yes or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 2 No 5 Residence 6 □Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After 1 Matural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NO05640> 16/24/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Yurow, MD Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

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			1- State of Maryland / Department of Health and Me Certificate of Death	ntal Hygier	711111	34079
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	n
		8	HARBOR HOSPITAL BALTIMORE			
I	Funeral		5 Social Security Number 6 Sex a 7 Age (In yrs, last hirthday) If Under 1 Year If Under 24 Hrs. 8	. Date of Birth (Month, Day, Ye	9. Birti	hplace (State or Foreign untry)
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	and *	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	with	by Funeral Director	1802 Wye Cliffe Court 21122		U.S.A.	
	Jeath Tris 2:	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci	fy Yes or No-	14. Race - Ame	
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Maryland	tal H	Be		17		
Ĕ	d Mei mark matic	ဥ	Felix Kuczvnski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R		erenc	Zin Code)
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination in the inclifted at once.		21. Signature Figure Service Licensee 22. Name and Address of Facility Gond			
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Division of	of or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Stree City or Town, S		urai Route Number,
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	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NICHOLAS A RAMEY, MD 300   SOUTH HANCVER ST. BALTI	MORE. M	7D 212	25
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Physician Midded  Examiner    Physician Mides   Physician Mides   Physician	Depar Depar	any Ir		21. Signature of Funeral Service	Haud	+ M	00764	HAIGH Sykes	r Ful ville	NERAL HOME, MD 217	IE & CH <i>A</i> 184 (41	PEL, 0)-79	P.A. ( 95-1400	Box 195)
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TO YEAR OF STATE OF S	per per pu	transit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events roculting in death) Last	c	`	Kidi	رمنم	for	ilus				2 years
FFEMALE   23c. If yes, outcome pf pregnancy   1   Live birth   2   Fetal death   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   Month   Day   Year   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   Month   Day   Year   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   Month   Day   Year   4   Pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   Month   Day   Year   1   Year   2   Month   Day   Year   1   Year   2   Month   Day   Year   1   Year   2   Month   Day   Year   Ye	ate be exemple and a	the bur	lical Ex	resulting in death) Last	d	o (or as a coi	nsequence of):	bet	es_					10 years
State 31. Date filed (Month, Day, Year)	the death certific	ched for use as	ıysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1⊡Live 4⊡Pre	e birth 2 🗆 gnant at time	Fetal death			/		2		
State 31. Date filed (Month, Day, Year)	es that	be deta		Part II. Other significant condition	ons contributing to	death but no	t resulting in th	ne underlyi <b>n</b> g	cause giv	en in Part I.				
State 31. Date filed (Month, Day, Year)	v requir	plnods	eted	( OP V	Sierie	nang	<i>ب</i> ر							
State 31. Date filed (Month, Day, Year)	The lay	page 2	Somp	Thy,	ear tens	d cm					aut	opsy formed?	prior to death?	completion of cause of
State 31. Date filed (Month, Day, Year)	VII.a sician: certific	rector,	Be	examiner?	Hospital:	The extent	OFFE Court	tiont 200	OA Oth	or:	17 9	v nil	Пон (С	- a/f-d
State 31. Date filed (Month, Day, Year)	TOF ig Phys ter this	neral di		27. Manner of Death	28a. Dat	e of Injury	28b. Tim		OA	4 Li Nursing F				эспу)
State 31. Date filed (Month, Day, Year)	ISIOI ttendir death.	the fu	icatio	2 Accident investig	gation			М	1		28f. Location	(Street and	d Number or R	ural Route Number,
State 31. Date filed (Month, Day, Year)	Ltal or A	ed in b	Certif	4 [[Hofficide	10				4					
State 31. Date filed (Month, Day, Year)	he Hospi n 24 hour ne Funer	pletely fill		(Check only 2 Medical	Examiner: On the	basis of exa	y knowledge, c amination and/	or investigatio	n, in my	opinion, death occ	e, and due to th urred at the time	e, date and	place, and du	e to the cause(s)
State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	To ti within	com	Ň	29b. Signature and title of certifie	400	long	ins	29	2			1		
State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	1	$\lambda$					1 1			Westn	rem ter	n	10 2	21157
	R			31. Date filed (Month, Day, Year)	32			Speck	,					

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:50 PM 2007 10 22 Hilda W. Leonard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Fallston 2705 Fallsmont Drive If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Days 1 ☐ M 2 💢 F 12/02/1916 Maryland 90 214-01-3355 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director Fallston Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21047 U.S.A. Funeral 2705 Fallsmont Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify ģ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Continental Can Co. Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Murphy Frederick Henry Wienecke ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21030 12 Iron Mill Garth - Hunt Valley, Maryland William Leonard (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Highview Memorial Gdns. 10/26/2007 Fallston, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. and ture of Funeral Service Licenses 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons auence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last consequence of): Due to (or a Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Sesidence 6 ☐ Other (Specify) 200 2 ER/Outpatient 3 DOA 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending investigation

/Medical **Examiner** and The law requires that the death certificate be exect Division or Vital Records, P.O. Box 68760, attending physician for use as the huria ector, page 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, pa

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

or items

'natural",

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once.

**Physician** 

the Medical Examiner

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ģ Be Certification: To Medical

Completed

0

Registrar

State

308 31. Date filed (Month, Day, Year)

OCT 2 4

2007

29b. Signature and title of certifier

2 Accident

3□ Suicide 4 Homicide

29a, Certifier

6 ☐ Could not be

determined

and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER WAY

#egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 unior 600 /Medical 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner NA Baltinoi Derdek If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 42-464 Months Days 1**X** M 2□ F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. Cify. Town or Location a or 28a-f show be notified at 10b. County Batimore 1 XYes 2 No by Funeral Director yary land 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a of Examiner must b permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must anone. 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marce ustodian 4 Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 4nch ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son Baltimore e55e 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State undalk, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licenses hatman- Harn's Baltimore, MS 21206 Road tarres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician month (Deneralised disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Emall Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Vear in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 □Yes 2 □ No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

C. Macing

OCT 2 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

516 N 32. gistrar's Signature

MD

2007

MD

Rolling

29c. License number

D45274.

29d. Date signed (Month, Day, Year)

10/22107.

MD 21128

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 1- State Amend #20b Per FH C874 12/12/07 Jh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** USOH AM Ear /Medical 4a. Facility Name (If not institution, give street and numbe, 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial nion MONE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. 2 38 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Min 1 □ M 2 F 218-78-2293 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, the Medical Examiner miles because once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits It: more MD 1 es 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4.5.1 21218 DIEEN MOU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Atro 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ un 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (10 quardian 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/05/2007 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \Lambda f Fyneral Service Licensee .MD 21216 NONK 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) terioscl **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension After this certificate has been signed by the attending physiclan and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 moviths? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by etardation 1 TYes 2 No 3 Probably 4 Unknown Disorder Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2□ No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 □Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2007

32. Segistrar's Signature

an	1 - State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland		tificate o		2. Date of	Reg. No.	001	3 4 0 8 l		
		Masters, Jr.				Month	Day	Year 2, 2007	5,600 91809		
cal ner	Norwood LeRoy  4a. Facility Name (If not institution, give s			4b. City, Town	or Location of			County of Dea			
iei	5018 E. Biddle S			•	altimor			,			
	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Yes			Birth Day, Year)	9. Bir	thplace (State or Fore		
	2//-50-/5/9	<sup>3M 2□ F</sup> 56	Yrs.	Months Day	S Hours	Dec.			hio		
	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	ation					10d. Inside City Lin		
j		Toc. City,	TOWN OF LOC	_					1X Yes 2		
Director	Maryland N/A			Balt:			10- 00				
				10f. Zip Code	205		iog. Cit	izen of What Co			
Funeral	5018 E. Biddle St	Was Decedent Ever in U.S.	13 W			jin? (Specify Yes or	No-	14. Race - Ame			
Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	lf.	Yes, specify C	ban, Mexican	Puerto Rican, etc.)		Black, Whit			
þ		If Yes, Give Year or Dates:	1	☐ Yes 2X N	o Specify:			Specify: W	hite		
Completed	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occ	upation	-44/	16b. K	ind of Business	/Industry		
ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	kind of work doi OO NOT use ret	ie during most red)	of working					
COL	11			Pressm	an		P	rinting	Company		
Be (	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Mide	dle, Maiden	Sumame)			
2	Norwood L. Master	s, Sr.			Myrt	le Mae Pi	erce				
	19a. Informant's Name/Relationship (Type	(Brother	19b. Mailing	g Address (Stre	et and Numbe	r or Rural Route Nur	nber, City o	r Town, State,	Zip Code)		
	William LeRoy Mast				Avenue	e, Baltimo	-4	-			
	20a. Method of Disposition  1 X Burial 2 Cremation 3 R	001	ice of Dispos metery, crem	sition (Name of atory or other p	lace)	Date	20c. Lo	ocation - City or	Town, State		
	`4 □Donation 5 □Other (Specify)		dens	of Fait	h 10	)/25/2007	Balt	imore,	Maryland		
	21. Signature of Funeral Service License	99			ress of Facility	Schimunek	Fune	ral Hom	ne Inc.		
	Mul	1	97	05 Bela	ir Rd.,	, Nottingh	am, M	laryland	1 21236		
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a conseque	sem	na							
Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	33c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3□	Ectopic pregna Other (specify)				23d. Date of de Month	livery Day Year		
by	Part II. Other significant conditions cor	stributing to death but not result	ting in the un	derlying cause	given in Part I.		id tobacco u ∐ Yes 2	~	o the cause of death robably 4 Dunkn		
							-				
						pe	itopsy informed?	prior to death?	utopsy findings avail completion of cause		
						of Death (Check on		1 Tes	s 2 No		
Completed	25. Was case referred to medical					OI DEATH CHECK ON	ly one)		aciful)		
o Be Completed	25. Was case referred to medical examiner?	Hospital: 1   Inpatient 2   F	B/Outnation	30004	)th an	reing Home 5XP	Home 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred				
To Be Completed	examiner? 1 □ Yes 2 No  27. Manner of Death Natural 5 □ Pending	1   Inpatient 2   E	R/Outpatient 28b. Time of Injury	28c. Ir	Other: 4 🗆 Nui	28d. Descri					
To Be Completed	examiner? 1 Yes 2 No	28a. Date of Injury	28b. Time of Injury	28c. Ir V	Other: 4 Numbers   Numbers	28d. Descril	oe how injui	ry occurred  and Number or R	lu <i>ral R</i> oute <i>Numb</i> er,		
Certification: To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hon	28b. Time of Injury	28c. Ir V M 1	Other: 4 Num  Numy at  Ork?  Yes 2 Nume  time, date and	28d. Descril No 28f. Locatio City or	n (Street an Town, State	nd Number or R	s stated		
To Be Completed	examiner?  1   Yes 2   No  27. Manner of Death   Natural   5   Pending	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hon building, etc. (Specify)  sician: To the best of my knowner: On the basis of examination	28b. Time of Injury	28c. Irv M 1  pet, factory, office occurred at the estigation, in m  29c. Lice	Other: 4 Number Address Number Address Number Number Address Numbe	28d. Descril No 28f. Locatio City or d place, and due to the occurred at the tin	n (Street an Town, State he cause(s) he, date and	ny occurred  and Number or R  and manner a d place, and du  te signed (Mon	s stated. e to the cause(s)  th, Day, Year)		
Certification: To Be Completed	examiner?  1   Yes 2   No  27. Manner of Death   Natural   5   Pending	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hon building, etc. (Specify)  sician: To the best of my knowner: On the basis of examinating and manner stated.	28b. Time of Injury  ne, farm, stre  rledge, death on and/or inv	28c. Ir v M 1 1 29c. Ir v M 29c. Lice 29c. Lic	Other: 4 Number Address Number Address Number Number Address Numbe	28d. Descril No 28f. Locatio City or d place, and due to the occurred at the tine	n (Street an Town, State he cause(s) he, date and	ny occurred  and Number or R  and manner a d place, and du  te signed (Mon	s stated. e to the cause(s)  th, Day, Year)		

DHMH 17 Rev 1/2001

07-08179 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Naron Moore State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day October 20, 2007 Medical Examiner 1602 hrs AKOUE ORE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MA University Hospital **Baltimore** 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY Birthplace (State or Foreign Country) HAEY land Months Days Hours Min. Director 1 X M 2 Yrs Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once. BAITIMORE Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21215 2609 Fairview Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Widowed Divorced If Yes, Give Year Specify ATTICAN HARICAN 4 Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 5 th ges I and 2 should be filed within of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 tareview AUC- BAILIMERE, MARGIAND 21215 (Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematogy or other place) Burial 2 Cremation 3 Removal from State ?100 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL GERVICE Vancy M. Wallace Funeral Services W. FRANKLin Street - Bartimica aclace MARYlAnd MEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failur. List only one cause on each line Between Onset and /Medical Death a. Small bowel obstruction Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hirschsprung disease Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 1 🗸 Yes No 25. Was case referred to medical 26.Place of Death (Check only one Be Hospital: 1 / Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural within 24 hours after death. Pending Yes 2 To the Funeral Director: the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E October 21, 2007 30. Name and address of person who completed cause of death (tem 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DOME

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Physician Russell Warfield Myers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number Sex XXM 2□F 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 80 216-22-9216 Director Dec. 19, 1926 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. inside City Limits "natural", or items 23a or 28a-f show cloal Examiner must be notified at XXYes 2 □ No Director Maryland Carroll Manchester 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or items 1 is marked other than "natural", or items 23a or items 1 injury or other traumatic event, the Medical Examiliar must be none. 3231 Maple Avenue 21102 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? YXYes 2 No 1950- Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. YYes 2 If Yes, Give 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo 2 1952 Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th <u>Technician</u> <u>Wrights Radio</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Warfield Myers Edna Larue Yingling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha E. Myers (Wife) 3231 Maple Avenue, Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State No character of Disposition (value of Church) Oct. 26, 1XXBurial 2 □Crea 3 Removal from State 4 ☐ Donation 5 ☐ Other (\$pecify) 2007 Manchester, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 21. Smature of Fun Alervio Lic nee LAMay At Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm mate Cause (Final ACUTE PULMONARY EDEMA **Physician** disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY ISCHEMIC YEARS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAILURE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed MELLITUS DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1X Natural 2 ☐ Accident 5 Pending investigation injury after death.

1 Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Lexcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10-23-07 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, WESTMINSTER, MD 21157 MEMORIAL FRANCIS KHOO. 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Judy Malinauskas 7:05 P <sup>M</sup> 10-15-2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6358 Bayberry Ct. Elkridge Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 20 F 61 Director 214-46-1835 04-05-1946 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits r 28a-f show notified at Director MD 1 ☐ Yes 2 ☑ No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 6358 Bayberry Ct. 21075 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: þ Specify: White 3 ☐ Widowed 4 M Divorced "natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Healthcare Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice F. Gorman Bettye A. Lindley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Ronald Malinauskas/son 1400 Irishtown Rd.. New Oxford, PA 17350 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 10-22-2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 about art1. Enter the dise plical a.s.1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Byeon Melasterti elanomo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1∐ Yes 2 ☑ No this certificate director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide MSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760. To the Hospital o within 24 hours aff To the Funeral D

> State Registrar

29b. Signature and title of certifier

Carole

29c. License number

N35254

atomare Baltimore MD21229

29d. Date signed (Month, Day, Year) 10-17-07

and manner stated.

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Pregistrar's Signature

Miller

2007

2 4

		1	For State	State of Marylai		ent of Health and ate of Death	d Mental Hygie Reg.		01000
m <sub>y</sub>			Registrar  1. Decedent's Name (First, Middle, Las	0 11 11			2. Date of Death Month	Day Year	3. Time of Dear
/	ysicia Medic	al _	Aa. Facility Name (If not institution, give	of Idred N		ity, Town, or Location of De	Catober 1	4c. County of Death	10:15 AM
Ε)	camino	<b>₽</b> 1	26 N. Wolfe	2 Street	16116	Baltimo der 1 Year   If Under 24 H	C R Date of Birth	N/A	ice (State or Foreign
	neral ector	4	5. Social Security Number  3/7-24-43-2/  1  Usual Residence of Decedent	PX 7. Age (In yrs	(a. last birthday) If Un Yrs. Mont			ear) 930 Mo	y/ord
aryland show	d at	.	10a. State 10b. County		ity, Town or Location	altimore		100	d. Inside City Limits 1 XYes 2 □ No
ith the M	e notifie	Director	10e. Street and Number		10f.	Zip Code	109	. Citizen of What Countr	y?
death w	r must t	<u>a</u>	26 N. Wolfe  11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Do	ecedent of Hispanic Origin? specify Cuban, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Black, White, et	
1215-0036 within 72 hours after death with the Maryland ene.	Ехаш	۾	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Pivorced	1 □ Yes 2 No If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:		Specify: B	lack
21215-0036 d within 72 hours af giene. "natural" on	other traumatic event, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	life. DO NO	work done during most of Tuse retired)		Hary land	121
N P D	nt, the		17. Father's Name (First, Middle, Last)		Cla	18. Mother's I	Name (First, Middle, Ma	National  iden Surname)	Bank
arylanc	tic eve	To Be	Percy Mi	·ller		a	llegra.	Rowlett	
Maryland Id 2 should be filt Ith and Mental H	trauma		19a. Informant's Name/Relationship (	1 /	19b. Mailing Add	ress (Street and Number of	Rural Mute Number, C		231
E 75	other		20a. Method of Disposition	20b	Place of Disposition cemetery, crematory	Name of or other place)		Oc. Location - City or Tow	
Baltimore, permit. Pages 1 a Department of Hee	lury or		1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)	v) Di	larey Va	Usy Mom. ( e and Address of Facility	sorders	Timonium	1/1/1
Balti permit. Departm	any Injury o		21. Signature of Funeral Service Licer	- Carris	4210	Belair Roa	d Balti	more, MD	21206
I S			23a. Part1. Enter the disease, or com shock, or heart failure. List only					)	Approximate Interval Between Onset and Death
Phys /Me	ician dical		Immediate Cause (Final disease or condition resulting in death)	a. Own IC		ctrice pula	ionary o	(16016	311
Exan	niner		Se uentially list conditions, if any, leading to immediate	b	Constitute Alle				
₩ Per .	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ביים וני (טו מא מ טטוואי	equence or).				
sate be executed	priysician and s the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):				
687 tificate	g priys	fedical		⊾d					
O. Box 6	been signed by the attending Is should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3□Ector	oic pregnancy r (specify)		23d. Date of deliver Month	ry Day Year
ords, P.O	ned by e detac	by Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the underly	ng cause given in Part I.		acco use contribute to th	
ords require	d pinou	ted b	- Cachexia	1			1Yes		ably 4 Unknown
(i) (ii)	2 33	Completed	- My Poxia				24a. Was an autopsy perform 1 Yes 2	ed2   prior to condeath?	psy findings available inpletion of cause of
or Vital Physician: T	Affer fnis certificate na funeral director, page	Be C	25. Was case referred to medical examiner?			0.45	Death Check onl one		
or Vita Physician:	r mis c eral dire	은	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	28b. Time of	DOA Other: 4 Nursi 28c. Injury at Work?	ng Home 5 Resider  28d. Describe hor	nce 6 □Other (Specify w injury occurred	<u>/)</u>
/ision Attending	or: Arre	atior	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b		M	1 ☐ Yes 2 ☐ No	-	and and Alicenbarra Brown	I Davida Alumbar
Division of or Attending	Direct d in by 1	Certification:	3 Suicide 6 Could not be determined		t home, farm, street, to ecify)	ictory, office	City or Town	eet and Number or Rura State)	r noute Number,
Divisio  To the Hospital or Attendi	le Funera	Medical C	29a. Certifier 1 € Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death occ nination and/or investig	urred at the time, date and pation, in my opinion, death	occurred at the time, da	ate and place, and due to	o the cause(s)
To th withir	To the count	Me	29b. Signature and title of gertifier  Han  30. Name and address of person who  Alau Imme	Luml	ni	29c. License number	+3	d. Date signed (Month,	Day, Year)
	Y		30. Name and address of person who	completed cause of death (I	tem 23a) (Type, Print)	arles 5+	Bult	Md 212	04
4		ate	31. Date filed (Month, Day, Year)	32 Hedistrar's Si	gnature				
DHMH 17	Regist	-	OCT 2 4 2	007 Stewar	15 Agreed				
					ORIGI	VAL			

		1	For State		State o	f Maryla	nd / Depa <i>Cer</i>	rtment of H <i>tificate of l</i>	ealth and M D <i>eath</i>		Reg. No.	007	3408	39
	7	1	Registrar  I. Decedent's Name	e (First, Middle, L	ast)					2. Date of Dea		Year	3. Time of Dea	
	Physicia /Medic	al	Lewis E F							October		ounty of Death	11:00A	М
	Examin		ia. Facility Name (f. 11823 Harfo		iive street and nu	mber)		Baltimore	Location of Death  County		1	timore		
	Funeral Director	8	5. Social Security N 217 36 442	/	Sex 1 M 2 F	7. Age (In y. 107	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da January	<sup>h</sup> 12°°190	9. Birth Balti	place (State or Fo. ntrv) More Co.,	
T-file	D	-	Usual Residence of 10a. State	f Decedent 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Li	imits
	Maryla f shov		Maryland	Baltimor	e		Baltimore	County					1 □ Yes 2 🖁	₽No
	or 28a-	Funeral Director	10e. Street and Nu					10f. Zip Code 21057			10g. Citize	en of What Cou	intry?	
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36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fund	11. Marital Status 1 ☐ Never Mari 3 ☒ Widowed	ried 2 Married 4 Divorced	Armed F	orces? 2[ <b>X</b> No ilve		if Yes, specify Cuba 1 □ Yes 2 No	an, Mexican, Puerto Specify:	o Rican, etc.)		Black, White Specify: Wr	ite	
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could r	ot be 28e. Pla	ace of injury - uilding, etc. (S	At home, farm, s Specify)	street, factory, offic		28f. Location City or 7	(Street an own, State	d Number or F	Rural Route Numb	e <i>r</i> ,
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	To the within To the complex	Me	•	and title of certifie	gus			Dog	nse number ) 18424		OCT		nth, Day, Year)	
	5		30. Name and a	ddress of person	who completed o	ause of death	(Item 23a) (Typ	e, Print)	FALLSTO	N,MD-	210	47		
		tate	31. Date filed (N	Month, Day, Year)	3	2. Registrar's	Signature			/				
	Regis			OCT 2 4	2007	1500	St Pro	548.5						

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:40 AM Isabelle 15, 2007 October Ruth Petersen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Rennaisance Gardens Nursing Center Gatolisville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | June 18, 1917 7. Age (In yrs. last birthday) 90 vrs 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** New York 1 □ M **X**XF Months Days Director 121-09-1696 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No Director Catonsville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21228 709 Maiden Choice Lane #422S Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Connecticut College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public Schools Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethe1 Pearsall Wallace Payn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 506 Elm Ave., Takoma Park, MD 20912 Daughter Joan Clement 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 10/18/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 2 21. Signature of Funeral Service m00382 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and physician ar s the bunal-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After this funeral of 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 10-16-67 Name and address of person who completed cause of death (Item 23a) (Type, Print) (ano 15 hoice March 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 4 All Mary 2007 Registrar

# MELVY PAYSNER Baltimore, Maryland 21215-0036

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Registr	ar	OCT 2	£ 2007		1 155	AN TO CHANGE						

07-07818 June Pivalo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 34092

	1- For State Certificate of Death Reg. No.												
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Director			1 M 2X	F 49	Yrs	Months Day	ys Hours	Min.	June	19,	1958	Country)	
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of fleath and Mental Hygiene.  Taut: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 X Other S	pecify: in	state									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ľ	21. Signature of Funeral Service Ronal d	Licensee	Director	22.1	Name and Addre	ss of Facility	0020	1 655	T.7 D	oltima	oro Ctr	root
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To the How within 24 h To the Fur	Medical Certification:		and ma	nner stated.			ense number					ed (Month, Da	
	Σ	29b. Signature and title of certi	ner								_		ay, 1 Car)
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		30. Name and address of person	on who complete	d cause of death (Iter	n 23a)								
		Ling Li, MD Assist				eet, Baltimor	e, MD 212	201					
		31. Date filed (Month, Day, Yea		32 Registrar's Signat	ure 🖋								
	रः।(भ	S. Date med (Month, Day, rea	2007	W.	S AL	all I							

ORIGINAL

OCME

DHMH 17 Rev 1/2001

07-07881 Robert Reed Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ert Reed	1-	State of Maryland / Departing For State Certific	cate of Death	Reg. No	
Physicia		egistrar I. Decedent's Name (First, Middle,Last)		2. Date of Death  Month  Day	3. Time of Death 0010 hrs
al Examin	er	Robert Reed	4b. City, Town, or Location of Death	October 10, 2	4c. County of Death
	4	a. Facility Name (if not institution, give street and number) Suburban Hospital	Bethesda	i	Montgomery
Euporal	5	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	M/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director	l	438-13-0555   1X M 2 F   49 52	Yrs. Months Days Hours Min	May 29,	1058 Country Louisana
- ke		Usual Residence of Decedent  10a, State 10b, County 10c, City, Tow	n or Location		10d. Inside City Limits 1 Yes 2 X No
d how a		DC Wash	nington		Citizen of What Country?
death with the Maryland r Items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number 800 E. Capitol Street NW	10f. Zip Code 20003	10g. 0	USA
ith the 23a o		11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	ipecify Yes or No-	14. Race - American Indian, Black, White, etc.
	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	1 Yes 2 X No specify:	y rudding dreey	Specify: white
5-0036 ed within 72 hours after death tygiene. other than "natural", or iter the Medical Examiner must		Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16	a Decedent's Usual Occupation (Give kind of		Sb. Kind of Business/Industry
, MD 21215-0036 and 2 should be filed within 72 hours after eacht and Wental Hygens them 27 is marked other than "natural", traumatic event, the Medical Examiner.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		
5-0036 iled within 72 Hygiene. th other than	ם	12 4	self employed	ne (First, Middle, Mai	retail ice cream
D 21215-003 should be filed within and Mental Hygiene. 77 is marked other the natic event, the Med		17. Father's Name (First, Middle, Last) Edward Reed		icia Kars	1
2121 uld be fil Mental I marked c event,	Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or		
D 21 should and Me 7 is man	우	Karen Morse/spouse	800 Capitol Street	NE Washing	gon DC 20003 20c. Location - City or Town, State
imore, MD 2 Pages 1 and 2 shoul nent of Health and N tant: If item 27 is n or other traumatic		20a Method of Disposition 20b. Place	ce of Disposition (Name of cemetery, matory or other place)	Date 2	20c. Location - City of Town, State
nor ages lant of I nt: If		1 Burial 2 Cremation 3 Removal from State  4 Donation 5 X Other Specify: in state			
Baltimore, MD permit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat	1	21. Signature of Euneral Spice Licensee Ronal Spice Licensee Director	22. Name and Address of Facility State Anatomy Boar	sd 655 W.	Baltimore Street
		23a. Part I. Enter the disease, or complications that caused the death. D	Baltimore, MD 212 o not enter the mode of dying, such as cardiac	c or respiratory arres	t, shock, or heart Approximate Interval Between Onset and
Physician 'Medical		failure. List only one cause on each line.			Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):			
	ı L	Sequentially list conditions, start to immediate b. Cardiomegaly  Due to (or as a consequence of):			
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
ed sd	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and money a changed by the attending physician and control he deathed for use as the burial - transit	<u>a</u>	X UNPENDED X AMENDED DETAB. 23a-t	o,27,perME,g873, 11/27/07	TT	
60, ate be exe hysician a	Med	IF FEMALE: 23c. If yes, outcome of pregna	ancy		23d. Date of delivery  Month Day Year
687 ertifica ding p	ian/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pre th 5 Other (Specify)	gnancy	
Box 6876 re death certificate the attending ply ned for use as the	Physician/N	1 Yes 2 No 9 Unknown g Unknown		- B:444	bacco use contribute to the cause of death?
O. Entried	F.		sulting in the underlying cause given in Part I.		2 No 3 Probably 4 ✔ Unknown
ires the	o b				an 24b. Were autopsy findings available
ords w requ	Completed			autops	med? death?
Reco			26.Place of Death (Ch	1 Yes 2	2 No 1 Yes 2 No
tal F	B B	25. Was case referred to medical	lou -		Residence 6 Other:
of Vi	F	27 Mapper of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	1	now injury occurred
on on on on on on one on one on one on one one		1 X Natural 5 Pending	1 Yes 2 No		Day I Day to Number City
Division of Vital Records, P.O. ospital or Attending Physician: The law requires that the hours after death.  Increal Director: After this certificate has been signed by meral Director.	Cortification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, street, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificant within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy To the Funeral Director. After this certificate has been signed by the attending phy	I Cor		ge, death occurred at the time, date and place	, and due to the caus	se(s) and manner as stated.
o the lithin 2 o the l	ompiler Air	one) 2 Medical Examiner: On the basis of examination at and manner stated.	nd/or investigation, in my opinion, death occur	Ted at the time, date	29d. Date signed (Month, Day, Year)
To with	2 2	29b. Signature and title of certifier	O.C.M.E.		October 11, 2007
		30. Name and address of person who completed cause of death (Item	23a)	NAD 0400	14
		Patricia Aronica-Pollak MD. Assistant Medical I	Examiner 111 Penn Street, Balli	more, MD 2120	/ I
Rec	Sta		Sperke		
DHMH 17 Rev			ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) october 23, 2007 0430 **Physician** Rosalee M. Sypniewski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 831 S. Lakewood Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Days Hours Min. 1 □ M 2 💢 F 76 West Virginia 04/03/1931 Director 218-26-1915 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at ¥F Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 831 S. Lakewood Avenue 21224 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify. aryland 21215-0036 ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery Baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Kisemore Earl Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 831 S. Lakewood Avenue Baltimore, Maryland 21224 Nicholas G. Sypniewski - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) more, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2007 Baltimore, Maryland Oak Lawn Cemetery 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 weeks Physician Non small cull carrinoma of /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending physic for use as the b SYPNIEWSK 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Hypertension Be Completed Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an page 2 s certificate has autopsy performed? 1☐ Yes 2 XNo ie Hospital or Attending Physician: Ti 124 hours after death. ie Funeral Director: After this certificate letely filled in by the funeral director, pa Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Injury 1 Natural 1 □ Yes 2 □ No 2 Accident ROSA 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Polk

**DCT 2 4 2007** 

Registrar DHMH 17 Rev 1/2001

market

620 Boulton St.

29c. License number

D51788 (MD)

Bel Air MD 21014

29d. Date signed (Month, Day, Year)

10-23-2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Paul Schulman $P^{M}$ 10 - 14 --20074a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1239 Locust Ave. Halethorpe Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–30–1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Days 1**X** M 2□ F 218-28-5205 73 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Halethorpe Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 U.S.A. 1239 Locust Ave 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X1Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 10 Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Schulman Goldie Gart 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Schulman/Son 1239 Locust Ave., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 10/19/2007 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Carry L. Kaufinan Funeral Home At MMP, Inc. 7250 Washington Blvd, Elkridge, MD 21.075 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic lung 3 weeks disease or condition resulting in death) Due to (or as a consequence of) UNKNOWA ronare if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2□ No 12 Yes 2 □ No (Check only one)

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

**Physician** 

/Medical

10a. State

MD

by Funeral Director

Completed

Be

Examiner

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

burial-tran To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illed in by the funeral director.

Examiner Physician/Medical à Completed Be Certification: To 29a. Certifier Medical

1  Yes 2  No 9  Unknown	9□Unknown		and (specif	<i>y</i> /	0
art II. Other significant conditions					
chronic renal	msufficience	1 : TOb	allo	usery	_
Hypertension;	congestive	heart	failu	vre;	
Ischemic can	diomyopath	4: Co	PD		
25. Was case referred to medical	. ,	) /		26. Place of	Death
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursir	ng Hom
7. Manner of Death  1 → Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28

5 ☐ Pending investigation М

6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

5 Residence 6 □Other (Specify) 8d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

冠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

determined

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

DOOG 5934

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Modi, MD- 4660 Wilkens Ave \$100; Bathmore MD Seema 31. Date filed (Month, Day, Year)

State Registrar

10

32 Registrar's Signature

MD

07-08183 Do

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onna Scholliar		1- For State Registrar	Sta	te of Mar	yland			of Hea of Dea		Menta	ıl Hygi		ı. No.	20	07	340
Physici ledical Exam	an/	1. Decedent's Nan	me (First, Middle, Theryl So		n						N	Date of Death Month October 20	Day	Year 7		ne of Death
		4a. Facility Name University	(if not institution,			)		1	Town, or Lo	ocation of I		october 20		County of De		) bur
Funeral Director		5. Social Security 219–48–6	750	3. Sex		ge (In yrs. la	-	) If Un Mont	der 1 Year ths Days	If Under 2	Min	. Date of Birth	,	9. (PD/YYYY) 9. (Por	3irthplace eignWas Country)	(State or Shington D.C.
any		Usual Residence	of Decedent 10b. County			10c. City,	Town or Lo	ocation		<u>'                                    </u>					10d. I	Inside City Limit
<b>8</b>	or	MD	Anne A	rundel		Pasa	dena									Yes 2 X N
the Mary a or 28a-	Director	10e. Street and No. 575 Rive		oad					ip Code 122			1	g. Citiz USA	en of What C	ountry?	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygierne. 27 is medical the matural", or items 23a or 28a-f sha matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Man	ried 2 X Mar	ried Arme	ed Forces es 2	t Ever in U.:		If Yes, spec	cify Cuban,	Mexican, F		y Yes or No- an, etc.)		14. Race - Am White, etc		dian, Black,
urs after tural", o	þ	3 Widowed  15. Decedent's E	4 Divo	rced If Yes, Give or Dates: fy only highest		mpleted)		Yes dent's Usua			nd of work	done		Specify: Wh		у
6 n 72 hou ian "nat	Completed	Elementary/Sec 12	condary (0-12)		ge (1-4 or	5+)		g most of w istra	-				7. 15.11	LCIO		
215-0036 be filed within 7 ntal Hygiene. rked other than cut, the Medien	Som	17. Father's Name		_ast)		1	MILLET	Tacra				rst, Middle, M				
1215 d be file fental H arked o	Be (	Jessie W								Irene						
MD 21 d 2 should lth and Me n 27 is ma	<u>۵</u>	19a. Informant's N James Sc.			-		10.0							ty or Town, St ${ m MD}  2112$		(ode)
- P # E E		20a. Method of Di		3 Remov	al from S	1 .		sposition (N or other plac		etery,	D	ate	20c. L	ocation - City	or Town,	State
Baltimore, permit. Pages I at Department of He Important: If ite			5 Other Spe	ecify:				Memor						kridge		
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Physician - /Medical		23a. Pert I. Enter failure. List o	the disease, or conly one cause of	on each line.			. Do not en	ter the mod	e of dying, s	such as car	rdiac or re	spiratory arre	st, sho	ck, or heart		proximate Interv tween Onset an Death
xaminer		Immediate Cause or condition resul		a. Multiple  Due to (or	<u> </u>	sequence o	f):						_		+	
	ē	Sequentially list of if any, leading to		b	as a cons	sequence o	f):								+	
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executed an and al - transit		events resulting i		d												
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O. B. at the de diby the tached f	P.	Part II. Other sig		9	Inknown ing to dea	ith but not re	esulting in	the underly	ng cause gi	iven in Par	t I.	23e. Did to	bacco	use contribute	e to the ca	ause of death?
S, P.  uires th  signer  Id be de	ed by	ļ					<del></del>				{					4 Unknow
tal Records, P.O.  rian: The law requires that th  certificate has been signed by  ector, page 2 should be detach	Completed	j					_	. <u>-</u>				24a. Was autop	sy m <u>ed</u> ?	prior deat	to comple	etion of cause o
ian: Ti	Bec	25. Was case reference	erred to medical							of Death (	Check onl					
of Viting Physic After this	₽	1 V Yes  27. Manner of De	2 No	Hospital: 1	Date of In	jury	ER/Outpa	e of Injury		Other <sub>4</sub>	Nursing F	Home 5 Sd. Describe I			other:	
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그 무용함	Certifi	3 Suicide 4 Homicide	6 Could	not be 28e.		Injury - At h terstate/l		street, facto	ory, office bi	uilding, etc				and Number o		oute Number, C
To the Hospital within 24 hours a To the Funeral completely filled	lical	29a. Certifier 1 (Check only one) 2	Certifying Ph  Medical Exar	ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
To To con	Mec	29b. Signature ar	nd title of certifier		ner stated	d.		:	29c. License	e number			29d.	Date signed	(Month, C	Day, Year)
		Uan	fointe (	me y	nel				O.C.N	И.Е.			Oct	tober 21, 2	.007	
10		30. Name and ad Margarita	Fress of person Korell MD.	who completed Assistant				1 Penn S	Street, Ba	altimore,	, MD 21	201				
S Regis	State		onth, Day, Year)		2 <b>H</b> egistr	rar's Signat	ure	6-0-	-			_				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AM OCTOBER 2007 1:59 SANDS MARVIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REISTERSTOWN BALTIMORE FUTURECARE CHERRYWOOD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 80 Director 109-14-5309 NY 01/30/1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10b. County 1 ☐ Yes 2 No Director REISTERSTOWN BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. than "natural", or items 23a the Medical Examiner must b 302 CANTANTA COURT #400 21136 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No NAVY If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify WHITE 3 Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BILMOR PRODUCTS permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other the any injury or other traumatic event, the lonce. OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SILVERMAN UNOBTAINABLE SAMUEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 322 EAST CHATSWORTH AVENUE-REISTERSTOWN, MD 21136 <u>EVAN\_SANDS / SON</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition HILLTOP SERVICE CORP. 10/24/2007 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TOWSON. MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS. INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildre. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBRO VASCOILAR ATH EROSCHEROTIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): burialphysician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MEZLITUS 1 | Yes 2 | No 3 | Probably 4 | Winknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? HUPERTENSION 24a. Was an page 2 s autopsy perform certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, P.O. | or Vital Records, Division

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

death. after

requires that the death certificate be executed or Attending

within 24 hours a

To the Funeral Director: After the completely filled in by the funeral

Medical n

Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEDO State

31. Date filed (Month, Day, Year) OCT 2 4

29b. Signature and title of certifier

3□ Suicide

29a, Certifier

4 THomicide

(Check only one)

6 Could not be

determined





28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

SmITH

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D28595

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SUITE 2B, BALTOMA 24209

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 10 lamakloe 159+50 01 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgome of Silver Speing APEX HEALTH Silver Spring If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09-25-1955 9. Birthplace (State Country) 6. Sex 10M 2□F Days Togo, NEST AFRICA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ res 2 ☐ No SILVER SPRING. HD MONTGOMER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20910 STEERS USA 2700 BACKUE. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PENATE DeNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Imania Washington Kossi **IAMAKLOC** LAWSON BUDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY HOUX, CN NELSON S. TAMAKLUE RUSSEH RUMO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State WASH, DC UNK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BIANCHI WASHOU 20011 BI4 UDSHUY ST NW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Due to (or as a consequence of) STROKE Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) STAGE RENAL DISEASE Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? encephalopathu 1 Yes 2 No 3 Probably 4 onknown hypertansion 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy diabetes dependent 2 No insulin 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred

**Examiner** requires that the death certificate be executed and physician a the as nse ō the signed by the

Box 68760,

P.0.

Division or Vital Records,

To the Hospitai

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

Completed by

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**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Its marked other than "natural"; or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trauonce.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical 2 2 should Completed need has page After this certificate Be 2 funeral Certification: within 24 hours after death.

To the Funeral Director; Af
completely filled in by the fu Medical

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

30. Name and address of person who completed cause of 363th (Item 23a) (Type, Print)

28b. Time of 5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year) Iniury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

2

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

0 60826

SILVER Sprung , no 20110-1484

Kshama Craw State

OCT 2 4 2007

6 ☐ Could not be

determined

Shama

1500 FOURST GUEN ROMO 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 07-07546 Alvin Tresvant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 34099

				For State			Certific	cate of	Death					Reg. N	0.		7 0403
led	Physic lical Exan		1.	Decedent's Name (First, Midd ALVIN TRESVAN									Date of D Month Septem	ber 26	Year 5, 2007		3. Time of Death 0746 hrs
4,			48	a. Facility Name (if not institution Holy Cross Hospital	on, give street a	nd number)		4	b. City, Tov Silver S		cation of			1	4c. County of Montgom	ery	
	Funera Directo			Social Security Number 578-58-8671	6. Sex		(In yrs. last bi		If Under Months		If Under Hours				M/DD/YYYY) 1943	9. Bir Foreig Co	thplace (State or In untry) WASH., DC
	w any			sual Residence of Decedent  Da. State 10b. County  DC			0c. City, Tow WASH ]	n or Location						_			10d. Inside City Limits 1 X Yes 2 No
_	Aaryland 28a-f show	once	<u> </u>	0e. Street and Number					10f. Zip C	ode				10g. (	Citizen of Wh	at Cou	ntry?
9	te Mary or 28a	lied at	וע	611 RITTENHOUS	SE ST.,	N.W.		20011							NITED	STA	TES
0	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygione. int: If item 27 is marked other than "natural", or items 23a or 28a-1 sho	201	_ L.	Marital Status     Never Married 2	12. Wa	is Decedent E ned Forces?	ever in U.S.	If Y	s Decedent es, specify	Cuban, I	Mexican,	n? ( Spe Puerto F	cify Yes o tican, etc.)	r No-	White	, etc.	ican Indian, Black,
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	nours a	xaun		15. Decedent's Education (Sp				a. Deceden during m	t's Usual O ost of worki	ng life. I	OO NOT	ing of wo	ed)		D. Killa of Da	3111033/	madoty
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	5-0036 iled within 7 Hygiene.	he Me	5 1	7. Father's Name (First, Middl	e, Last)								First, Mid		ien Surname	)	
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	ID 21215-0036 should be filed within 72 and Mental Hygiene.	atic ev	은 1	9a. Informant's Name/Relation KIM TRESVANT		nt)	4	196. Mailing	g Address RITTE	oHOU)	SE S	T.,	N.W.	WAS	H., D.	C.	20011
	s I and 2 shoft Health and If item 27 is	i a	1 2	20a. Method of Disposition					sition (Name	e of cem	etery,		Date	2	0c. Location	City o	r Town, State
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	Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2	njury or	2	Donation 5 Other Other Other Other	le Lic if see	1-1	100	22.1 CA	Name and A	Address MOF	of Facility	Y 14	125 M	ARYI	AND AV	/E .	N.E. 20002
	Physicia	_	- 1	23a. Part I. Enter the disc se	or complications	that caused	the death.	not enter t	the mode of	f dying,	such as ca	ardiac or	respirato	ry arrest,	shock, or he	art	Approximate Interval Between Onset and
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	certifi	ise as	Physician	past 12 months?	4	Live birth Pregnant at	t time of death		ther (Spec			- P 3					
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	Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 buous after death.	ector, page 2 should be detached for use as t	by P	Part II. Other significant cor	ditions contri	outing to deat	th but not resu	ulting in the	underlying	cause (	jiven in Pa	arti.					robably 4 Unknown
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	ital sician: s certi	rector	Be	25. Was case referred to med examiner?	Hospita	l: 1 Inpati	ent 2 🗸 E	R/Outpatie		OOA	Other <sub>4</sub>		ng Home	5 R	esidence 6	O1	her:
	of Vid g Physic	funeral di	L.	1 ✓ Yes 2 No 27. Manner of Death	28	sa. Date of Inj (Month, Day,	ury 2	28b. Time o	f Injury		ry at Wor		28d. De:	scribe ho	w injury occu	irred	
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	To the Hospital Within 24 hours	completely	ical	29a. Certifier 1 Certifyin one) 2 Medical	g Physician: To Examiner:On th	e basis of ex	amination and	e, death occ d/or investig	gation, in m	y opinio	n, death o	ccurred	at the time	e, date a	nd place, and	due t	o the cause(s)
	To the within	com	Medical	29b. Signature and title of ce	andi	nanner stated	l				se numbe						Month, Day, Year)
		المر		CON HA	0 4	AD (	)au			O.C	M.E.				Septemb	er 27	', 2007
1	I P			30. Name and address of pe	rson who comple	eted cause of	death (Item 2	23a)				D 0 1 5					3172
	2 or p			Carol Allan, MD	Assistant M	edical Exa	aminer '	111 Penr	Street,		iore, M	U 212	UT				
		Since	tate	31. Date filed (Month, Day, Y.	ear) 4 2007	32 Regist	rar's Signatur	for Contract of the Contract o	andis								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10<sup>Month</sup> **20**<sup>Day</sup> 2007 THROWER MATTHEW 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE TURNER STATION 219 CENTER STREET | If Under 1 Year | If Under 24 Hrs. | | Months | Days | Hours | Min. | 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number 08-26-1920 VA **X** M 2□ F 87 216-12-2443 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No TURNER STATION BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 219 CENTER STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 Nos 2 □ No I Yes, Give Year or Dates: 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No BLACK 3 ☐ Widowed 4 N Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PEARL BYRD EDMOND THROWER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2636 E. BIDDLE ST/ BALTIMORE, MD 21213 DOROTHY JONES/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST VET. 10-26-2007 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BALTO., MD 21217 neo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

and

physician

attending

**Physician** 

/Medical

10a. State

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**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examine and.

Baltimore, Maryland 21215-0036

with the Maryland

death v

Examine Physiclan/Medical þ director, page 2 should Be filled in by the

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entire Uniform Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 No 1 Inpatient Certification: To 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/1 rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

After

death.

24 hours after death Puneral Director:

within 2

Hospital

EASTERN 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE BALTHORE A. Registrar's Signature

BANKOVA, MO

WRA

2 4 2007



21224 (JOHN'S HOPKINS BAYVIEW

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 19, 2007 Peggy Ruth Thrift 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Baltimore Center Towson 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Dec. 5, 1925 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 □ M 2 🖁 F Months Days Hours Dec. 214-22-6880 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Parkville Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A 8627 Richmond Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years N/AHousewife Her own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Lee Charlton Bertha F. Smick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald F. Thrift 8627 Richmond Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/22/07 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyreral Service Censes 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6414 Belair Road Baltimore, 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of) ADULT RESPIRATORY DISTRESS SYNDROME if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MYOCARDIAL INFARCTION Due to (or as a consequence of) CORONARY ARTERY DISEASE IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 Other (specify) 9☐Unknown 9 ☐ Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopu performe 2 1 Yes 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA

**Examiner** The law requires that the death certificate be executed as the burial-transit and Division or Vital Records, P.O. Box 68760. attending physician asn for detached certificate To the Hospital or Attending Physician: : After this certifica e funeral director, p death. Director:

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

Be Completed by

Certification: To

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hyglene. and it if item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages Department of Important: If it any injury or o

Physician /Medical

Baltimore, Maryland 21215-0036

GASTROINTESTINAL BLEED ANEMIA ATRIAL FILBRILLATION 25. Was case referred to medical examiner? 1 🗌 Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certifier

D31826

10-21-0

TOWSON, MARYLAND 21204

State Registrar

LINTHICUM, RICHARD M. D. 32 Registrar's Signature OCT 2 4 2007 Lew .

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 8 2330 Z007 Washington 10 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Hyvore or 1 Year | If Under 24 Hrs. University Mcd. ( Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 □ M 2√2 F Director 578-24-8768 86 April 29, 1921 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Columbia 1 ☐ Yes 21 No MD Howard Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 USA 9338 Ourtime Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 ☐ Widowed 4 🖾 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. Personnel Management Analyst Atomic Energy Comm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be to Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic eve Conrad Griggs Grace Williams ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21045 Janice Sams/Daughter 9338 Ourtime Lane 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Potomac Baptist Church Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-27-2007 Hague, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 23a. P. rf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEDICH EXMINER Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) day /Medical (or as a consequence of): Due t Examiner Hematona Subdural 12 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Danne Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown signed to Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2-No or Attending Physician: : After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2∏ No မှ 1 poatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 Natural s after death.

I Director: Af
of in by the fur 1 Yes 2 No Fall 10/6/2007 UNK 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Nursing Home Minstrel Way, Columbia, THO 1 Certifying Physician: To the best of wy knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral I

completely filled

altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

5

32. Registrar's Signature

Green

29c. License number

Street Baltimore MP

10277

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 19 2007 Physician 10:35 PM Robert L Wallace /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 1800 Kittyhawk Road If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, January 7 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Chaumont, New York XX 099 12 7885 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Essex Maryland Baltimore by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 1800 Kittyhawk Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☆☆ Yes 2 □ No If Yes, Give Year or Dates: WW I Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White W II 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Wallace Engine Co. Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Lowe Roswell D Wallace ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1800 Kittyhawk Road Essex, Maryland 21221 Freda Wallace (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. October 22 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. For ature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Sepsis **Physician** Due to (or as a consequence of) Disease arkinson Years Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1☐Live birth 2☐Fetal death Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 21 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Presidence 6 □Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manne of Death 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, completely filled in by the within 24 hours a

Baltimore, Maryland 21215-0036

1211 State

Alexander 31. Date filed (Month, Day, Year)

29b. Signature and title of conflict

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Chen Registrar's Signature

Registrar

I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Bux

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

19099

29d. Date signed (Month, Day, Year)

21284

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Division of Vital Records, P.O. Box 68766 within 24 hours after death. The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Medical	(Check only one) 2 ✓ Medical Ex	aminer:Or	the basis	s of exami	nation an	id/or investiga	tion, in my	opinion	, death occ	curred at th	e time, date	and place	e, and due t	o the c	ause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month WASHINGTON **Physician** NTHONY 200 /Medical 4b. City, Town, or Location of Death BATIMINE, MD 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 217-23 BOL SECOLLOS HOUPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 1 M 2□F 215-80-239 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Belay Director Maryland 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Mamied 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) Sister Trina Washington 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) clair Road Balt, MD2124 22. Name and Address of Facility 21. Signature of Euneral Service Licenses Chatna ares 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 51700K **Physician** /Medical DISTRESS SYNDROMF Examiner RESPIRATON 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit LATENAL Division or Vital Records, P.O. Box 68760, 🦟 Due to (or as a consequence of): STAGE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ž Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide determined 4 ☐ Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo mopwell

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature



BAUIMONE

MD

BALTIMORE.

			1 - For State Registrar	State	of Marylaı		artment rtificate			and M		jiene	007	34	106
	Physici	ian	Decedent's Name (First, Middle	a, Last)							2. Date of Dea Month	Day	Year	3. Time of	
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under	1 Year	If Under		8. Date of Birth	1		place (State or ntry)	Foreign
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Daillmor	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The fillem 23a or 28a-f show any injury or other traumatic event, the Medical Exacts at most be indifficial once.		21. Signature of Funeral Service Ronal C	icensee Wade	irector		ate A 1timo			Sard 21201	655 W.	Baltim	ore S	treet	
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	ro the frospiral of Antanding Prysician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier Check only one) Certifyin 2 Medical I	g Physicien: To the Exeminer: On the land mai	e best of my kno basis of examina oner stated.	owledge, death ation and/or inv	occurred a restigation,	it the time	e, date and inion, deat	d place, a	and due to the ca	ause(s) and m ate and place,	nanner as si , and due to	ated. the cause(s)	
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			30. Name and address of person of AJAY RED.	who completed cau	/ ~	m 23a) (Type, De W	Print)	uy.	Blud	, /	Serses	da, 1	w.	20817	7,
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 4 2	007	Registrar's Sign	ature	les .	0	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Alam October Siraj /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Plata enter La If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 XM 2 ☐ F 79 214-65-1482 **Director** 8/1/1928 India Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ural", or items 23a or 28a-f show | Examiner must be notified at 1 ☐ Yes 2 No Director Md. Charles LaPlata 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 102 Morris Dr. 20646 Pakistan Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Asian 5 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pakistani Government Officer 10 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Mamoona Bibi Lateef Alam Shah 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 616 E Charles St., Suite 102, LaPlata, Md. 20646 Shah T. Alam /son other 1 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' jo Department of Important; If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 10/4/2007 Laurel, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Universal Mortuary 21. Sign ture of Funeral Service Avensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. 411 Kennedy St., N.W. Washington, DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final Physician D815 disease or condition resulting in death) /Medical as a consequence of) Multi-organ dystenction syndrone Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of P.O. Box 68760, Physician/Medical the IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? φ Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed I I be det significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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e Funeral Director: // 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year,

OCT 1 0 2007

32. Registrar's Signatur

Office

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. — Reg.

			State of Maryland / De State	epartment of He Certificate of D							
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Le	ocation of Death		4c. County of Dea	ath			
			SOUTHERN MARYLAND HOSPITAL		LINTON			GEORGES			
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Maryland	2 sho and is ma		, , ,	Mailing Address (Street an			-				
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Bait	permit. Depart Import any Inj		21. Signature of Fure al Service Licensee	22. Name and Address MARSHALL'S  4308 SUITLA	FUNERAL ND ROAD	HOME OF	MARYLAND, LAND, MD 2	INC. 20746			
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Ω	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one)  Medical Examiner: On the basis of examination and and manner stated.								
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U36 urs afte al", or i	þ	1 MNever Married 2 Marr 3 Widowed 4 Divorced	If Yes, 0	s 2 <b>⊠</b> No Give Dates:			1 ☐ Yes	2X No	Specify:			Spec	cify: W	hite
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IOCE, Maryland 21213-U036 ges 1 and 2 should be filed within 72 hours after death with the Manyland at of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at	d)	17. Father's Name ( <i>First, Middle,</i> Eugene P.									(First, Middle, I h Evans		ame)	
aryic should and Mer s mark umatic	ဥ	19a. Informant's Name/Relations				19b. Mailir	ng Addres	(Street	and Number	or Rural	Route Number	r, City or Tov	vn, State, .	Zip Code)
P, Mi		Willie Jean Ba	uhof, ni	ece	20h Piac	o of Dione	noition (Ma	me of	1		stersto			Town, State
more		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (5		m State	Sout	etery, cre n	matory or	other plac		0/9/	2007		field	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami once.		21. Signature of Funeral Service		ora-		2:	<ol><li>Name a</li></ol>	nd Addres	ss of Facility	Mye et, V	ers-Dur Westmin	boraw ster,	Fune MD 2	ral Home 1157
cate be executed cate be executed by sician and cate the burial-transit the burial-transit cate categories.	al Examiner	23a. Part) Enter the disease, or shook, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Linter Underthing Cause (Disease or injury that initiated events resulting in death) Last	b. Due	to (or as a to (or a) to (	consequer	nce of):	Lester	rea		720	m		stere	Britierval Between Onset and Death
Geath certifice attending and for use as	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	4□Pre	outcome prove birth 2 egnant at ti	Fetal de	eath 3	□Ectopic   □ Other (s		у			23d.	Date of de Month	olivery Day Year
cords, P.O. w requires that the sbeen signed by the should be detached.	b	Part II. Other significant conditi	ons contributing to	o death but	not resulti	ng in the u	underlying	cause giv	en in Part I.			_		to the cause of death? Probably 4 □Unknowr
Re la le has age 2	Completed			-							24a. Was a autop perfor		prior to death?	autopsy findings available completion of cause of s 2 ☐ No
or Vital F Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	☐ Inpatien	ıt 2∏EF		ent 3 🗆 🗅	OA Oth			<i>(Check only o</i> ne 5 ☐ Resid		Other (Sp	ecify)
		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	ng (N	ate of Injury fonth, Day	y Year) 2	8b. Time o		28c. Inju			28d. Describe h	now injury oc	curred	
or Atten or Atten iffer deat Director; in by the	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	ningd Zoe. Fit	ace of injur uilding, etc.	ry - At hom (Specify)	e, farm, si	M treet, facto		Yes 2 □ N	-	28f. Location (5 City or Tou	Street and No vn, State)	umber or F	Rural Route Number,
oifta urs erai	Medical Ce	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To I Examiner: On th and m	the best of	examinatio	edge, dea n and/or i	th occurre	d at the ti	ime, date and opinion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner a	as stated. ue to the cause(s)
To the Hosi within 24 ho To the Func completely f	Mec	29b. Signature and title of certifi		1 / /	_		2	9c. Licens	se number			29d. Date si	gned (Moi	nth, Day, Year)
1,92		1 John W	Midd	Mta	7			02	5 8	44	4	10/5	1/2	207
W3.		30 Name and address of person	Allehn	ause of de	eath (Item 2	3a) (Type	Brint)	R	& h	les	tuin	ster	ME	24157
St	tate	31. Date filed (Month, Day, Year	2007	2 egistra	r's Signatu	re	rast.	,						

		1	For State of Maryland / Department of Health and N  State of Maryland / Department of Health and N  Certificate of Death		eg. No.	
			1. Decedent's Name (First, Middle, Last)	2. Date of Dear Month		3. Time of Death
	Physicia /Medic		Lucy Evelyn Austin	Octobe		2:00 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dec	
			Beverly Living Center Westminster  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Car	
	Funeral Director		577-34-9183  1 M 2 X F 94 Yrs. Months Days Hours Min.	Jan 31	1913	rthplace (State or Foreign country) Mass
	land II	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Mary ehc	ğ	MD Carroll Westminster			1 ☐ Yes 2 ☐ XLo
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What 0	country?
	th wit	aiD	1234 Washington Road 21157		USA	
0	y within 72 hours after death with the Marylar jiene. r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinat must be motified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, specify Cuban, Mexican, Puerto If Yes, Give  1 Yes, Give  1 Yes 2 No  1 Yes	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
3	2 hou		15 Decedent's Education 16a Decedent's Usual Occupation	trin -	16b. Kind of Busines	s/Industry
ת ת	hin 72	Completed	(Specify only highest grade completed)  Elementary(Secondary (0-12) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  Homemaker		Own Home	
V	ed wit	Com			Maiden Sumame)	
	be fill	Be	17. Tatilot 3 Harris (7 Mat, Milesto, Essay)	a Brown	Maiden Surname)	
aryis	2 should and Mer is marks sumatic	٦ م	19a. Informant's Name/Relationship (Type, Print)  Gail J. Austin - daughter  19b. Mailing Address (Street and Number or Ru 940 W. Princess Ann		r, City or Town, State	Zip Code) VA 23507
ĕ,	1 and 2 Health em 27 ther tr				20c. Location - City of	
E	Pages ment of ant: if it ury or o		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1/06/2007	Hampstea	d, MD
gall	Departit Departit Import any in		21. Signature of Funeral Service Licensee  22 Name and Address of Facility  21 Type 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
			23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory ar	est,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.			Onset and Death
į.	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Character According Due to (or as a consequence of):	ما ا		S/pur-
	Examiner			anser	~	25/2
	bed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			16.100
•	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		····	10 gr
98/90	sicien b buri		a plyoned age			944
200	= 0.0	ledicai				
O. Box	he death certif the ettending shed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of o Month	delivery Day Year
<b>.</b>	res that the de signed by the e be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
g	w requires been sign should be	ed by		1 🗆 Y	'es 2 (No 3 □	Probably 4 □Unknown
Vital Records,	m w cu	Completed			sy prior to death	autopsy findings available o completion of cause of ? es 2 \sum No
E	lan: 'rifice	BeC	25. Was case referred to medical examiner?	ath (Check only o		
	hysic his ce I direc	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	T	lence 6 Other (S	pecify)
Division of	Attending Physician: rr death. ector: After this certific by the funeral director,		27. Manner of Death  1 Natural 5 Pending investigation investigation  28a. Date of Injury 28b. Time of Injury 4t Work?  MM  28c. Injury at Work?	28d. Describe h	ow injury occurred	
<u>s</u>	Nttendi death. ctor: A y the fu	icat	3 Suicide 6 Could not be	28f. Location (5	Street and Number or	Rural Route Number,
<u>≥</u>	ei or A s efter il Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Tov	vn, State)	
	To the Hospitel or Attending Physician: The Is within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	edicai C	29a. Certifier (Check oruly one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check oruly one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check oruly one)	e, and due to the urred at the time,	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)
•	WIL		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1015/20	00/
_	0		John In alletin no 688 Park Rd West	min ste	r MD:	21157
	Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  OCT 0 5 2007  Manual & Apallo			
_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 07-07769 Robert James Brown

2007 34111

		or State Amend #5 Per FH g874 12/	38/10 Tate 191	Death		Reg. No.		3. Time of Death
Physician/ dical Examiner	1.1	istrar Decedent's Name (First, Middle,Last) Robert James Brown			Mo Oc	te of Death onth Day tober 5, 200	Year 7	0909 hrs
gii al Examine.	4a	Facility Name (if not institution, give street and number)		4b. City, Town, or Loca Columbia	ation of Death		. County of Death Howard	1
		Howard County General	yrs. last birthday)		f Under 24Hrs. 8. D	Date of Birth(MM	/DD/YYYY) 9. Bir	thplace (State or
Funeral Director	5.(	36 Security Number 6. Sex 7. Age (In 1999) 6. Sex 1	92 <sub>Yrs</sub>	Months Days	Hours Min. Ju	ine 11,	1915 Foreig	ountry)New York
	_	ual Residence of Decedent a State 10b, County 10c.	. City, Town or Loca	tion				10d. Inside City Limits
w any		a. State 10b. County MD Howard		Highland				1 Yes 2 X No
-f sho	<u>.</u>	e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Cou	untry?
the Maryland a or 28a-f sho tiffed at ouce.		6731 Mink Hollow Road		20777			USA	rican Indian, Black,
with the rs 23a	1	. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. W	as Decedent of Hispan Yes, specify Cuban, Me	nic Origin? ( Specify lexican, Puerto Rical	Yes or No- n, etc.)	White, etc.	rican mulan, black,
r death with or items 23 must be no	1	Never Marned 2 Married 1 X Yes 2	No _	Yes 2 X No s			Op comy.	nite
s after ral", niner	- 3	X   Widowed   4   Divorced   If Yes, Give Yeer   1941     S. Decedent's Education (Specify only highest grade complete	-1940 Docade	onte Usual Occupation	(Give kind of work		Kind of Business	
hours Exam		Elementary/Secondary (0-12) College (1-4 or 5+)	during	most of working life. DC	O NOT use retired)	Ir		e Commerce
5-0036 ed within 72 hour tygiene. other than "natu		7	, A	Attorney			Commis	51011
d with	5/1	7. Father's Name (First, Middle, Last)		18.	Mother's Name (Firs		Green	
215 be file ntal H rked o ent, til	읽	George Brown	1.00 11.0	ing Address (Street a	and Number or Rural			ite, Zip Code)
21 ould bear s mar tic ev	2 1	9a. Informant's Name/Relationship (Type, Print )		East Capit				
MD d 2 sh lth an n 27 i		Brian P. Brown/Son	20h Place of Disn	osition (Name of ceme	etery, Da	ate 20	c. Location - City	or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ouce.	2	Oa. Method of Disposition  Buriar 2 X Cremation 3 Removal from State	crematory or	other place) itan Cremat	110710	/2007 A	lexandri	a, Virginia
timen ritant		Denation 5 Other Specify:  1. Signature of Funeral Service Licensee	22	2. Name and Address of	of Facility	47:	39 Balti	more Avenue
Bal Bermi Depar Impo		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	191 G	asch's Fune	eral Home	, PA Hy	attsvill	e, MD 20781
Physician	1	Sa. Part I. Enter the disease, or complications that caused the	e death. Do not ente	er the mode of dying, su	uch as cardiac or re	spiratory arrest,	snock, or neart	Between Onset a
Viedical	- 1	failure. List only one cause on each line.  mmediate Cause (Final disease a. Chest and neck	k injuries com	nplicating athero	sclerotic card	diovascular	disease	Death
aminer	-	or condition resulting in death)  Due to (or as a consequence)	uence of):					
		Sequentially list conditions,  frank leading to immediate  Due to (or as a consequence)	wansa off:					
	<u> </u>	if any, leading to immediate Due to (or as a consequence). Enter Underlying Cause	Jence on.					
d		(Disease or injury that initiated events resulting in death) Last	uence of):	, · · · · · · · · · · · · · · · · · · ·				
tra du	Medical	d UNPENDED AMENDED						
760, cate be exe physician the burial -	좕	IF FEMALE: 23c. If yes, outcome		2	Estania pregnana		23d. Date of del Month	Day Year
387 rtifica fing p	an'	3b. Was decedent pregnant in the past 12 months?		Fetal death 3 Cother (Specify)	Ectopic pregnance	y		
Box 687 e death certific the attending p	sician/	1 Yes 2 No 9 Unknown g Unknown	5	Other (Specify)				
ires that the designed by the state of the detached for	Phy	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause g	iven in Part I.			e to the cause of death
P.O.	5					1 Yes		Probably 4 Unknow
ords, wequires	Completed					24a. Was an autopsy	prio	re autopsy findings avail r to completion of cause
orc aw re has be 2 sho	agr.					perform		th? ▼ Yes 2 N
Rec The I	6			26.Place	of Death (Check or			
Vital Recorysician: The law in this certificate has larector, page 2 st	Be (	25. Was case referred to medical examiner?	nt 2 🗸 ER/Outpa				esidence 6	Other:
Division of Vital Records, tal or Attending Physician: The law requirers after death.  "al Director: After this certificate has been sited in by the funeral director, page 2 should be a should by the funeral director.	2	1 Yes 2 No	ry 28b. Tim		ry at Work?	28d. Describe ho	w injury occurred	t
ing Ph After t		1 Natural 5 Rending FOUND: Day,Ye	ear) FOUND		Yes 2 🗸 No	resser iei	on subjec	
SiOr sittent death death sy the	cati	2 Accident Investigation Oct 5, 2007	0813 hr	rs, street, factory, office b	building, etc.	28f. Location (St	reet and Number	or Rural Route Number,
ivis	Certification:	Suicide 6 Could not be determined (Specify) Sin			6	721Mink Hol	ite) low Road, Hig	hland, Md
		4 Homicide		occurred at the time, da	late and place, and o	due to the cause	(s) and manner a	s stated. e to the cause(s)
Lospital Tospital Tuneral		29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inve	estigation, in my opinion	11, 200111 0000110	the time, date a		(Month, Day, Year)
Division of Vital Records, P.O. Box 687 the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending Impletely filled in by the funeral director, page 2 should be detached for use as it.	g;			29c. Licens	se number		Zau. Date signet	(1.10) (1.1) = 3), (33.)
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29b. Signature and title of certifier			NAF	l	October 6 2	2007
To the Hospital within 24 hours To the Funeral completely filled	Medica	29b. Signature and title of certifier  When I have bould	leath (Itam 22a)	o.c.	.M.E.		October 6, 2	2007
To the Hospital within 24 hours To the Funeral completely filled	Medica	29b. Signature and title of certifier	leath (Item 23a) Examiner 1	O.C.		21201	October 6, 2	2007

		1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment rtificate	of He	alth and M eath		eng 0 0	7	34112
Phys /Me	ician dical	Decedent's Name (First, Middle, Last)     Leonard	J	Bick	Ley			2. Date of Death October 6,	Day	Year	3. Time of Death 5:00 A M
	niner	4a. Facility Name (If not institution, give: 13312 Reid Lane	street and number)				ocation of Death		4c. County o	_	e's
Funer Directo		5. Social Security Number 6. Sec. 159—34—4660 112	7. Age (	(In yrs. last birthday) 93 Yrs.	If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 9, 19	(9ar) 14	9. Birthp Cour	elace (State or Foreign ntry) England
hours after death with the Maryland tural, or items 23e or 28e-f show at Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Georg		10c. City, Town or Lo Ft. Was	shingto						0d. Inside City Limits 1 ☐ Yes 202 No
th with t	ai Dir	10e. Street and Number 13312 Reid Lane			10f. Zip	20744		10	g. Citizen of WI		ntry?
72 hours after des natural', or itama licsi Examiner m	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:		Was Deced I Yes, spec 1 ☐ Yes 2		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		White,	ean Indian, etc. hite
within 72 ane. then "nat	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usua kind of won DO NOT us ECOM. E	k done dur e retired)	ing most of worki	ng	Sb. Kind of Bus		
be filed stal Hyg of other	To Be Co	17. Father's Name (First, Middle, Last)	Bickley			18	8. Mother's Name Agnes	(First, Middle, M Hollar		)	
and 2 shoutd Batth and Mer n 27 ie marke		19a. Informant's Name/Relationship (Ty. Norman Lesko / Friend	pe, Print)					on, Maryla		ta <i>te, Zip</i> 744	Code)
一工事意		20a. Method of Disposition  1	emoval from State	20b. Place of Dispo cemetery, crei Kalas Crer	natory or ot	ne of ther place)	10/08/		oc. Location - C Edgewate	-	
permit. Pages Department of Important: If it any injury or or	SUC	21. Signature of Juneral Service License	les fr.	22	2. Name and			eorge P. Ka ron Hill, N	las Fune bryland		lome PA 1745
Physicia /Medica Examine	al er	23a. Fart Enter the disease, if complished, or heart failure. List only or timediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, tay, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		er the mode	e of dying, s	such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death 3 Months
icate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
death certit e ettending id tor use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. tf yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetat death 3	Ectopic pre				23d. Date Mont		ery Day Year
requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions cor	tributing to death but	not resulting in the u	nderlying ca	ause given i	in Part I.				ne cause of death?
4 N CA	Completed							24a. Was an autopsy perform 1 Yes 2	ed? de	ath?	psy findings available mpletion of cause of 2 No
Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No	ospital:	2 ER/Outpatier	it 3□ DO/	_		n Check only one	7	/Specifi	d
fter	ation: T	27. Manner of Death  X⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day )	28b. Time of		8c. Injury at Work?		28d. Describe how			//
To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory,	, office		28f. Location (Stre City or Town,	et and Numbei State)	or Rura	l Route Number,
o the Hospital or dithin 24 hours ette to the Funeral Dir ompletely tilled in	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medicat Examin	nician: To the best of oner: On the basis of example and manner state	xamination and/or in	occurred a vestigation,	at the time, in my opini	date and place, a ion, death occurr	and due to the cau ed at the time, dat	ise(s) and man e and place, ar	ner as si	ated. the cause(s)
To I To I	W	29b. Signature and title of certifier	oner		29c.	License n	umber 46285		d. Date signed Ctober 8		
(7)			905 Ft. Wash	ington Road	Print) #206	Ft.	Washingto	on, Marylar	d 2074	44	
Regis	State strar	31. Date filed (Month, Day, Year) OCT 1 0 2007	32. Registrar's	s Signature							-

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ral", or Items 23a or 28a-f shov Examiner must be notified at

"natural"

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

State Registrar

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 1 3 Probably 4 Unknow  24a. Was an autopsy performed 2 death?
Hospital: Other:	1
28a. Date of Injury (Month, Day Year) ation  28b. Time of lnjury  28c. Injury at Work?  1  Yes 2 No	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29c. License number	· 29d. Date signed (Month, Day, Year)
	1

DHMH 17 Rev 1/2001

Dr. Elaine Arata

OCT 0 9 2007

31. Date filed (Month, Day, Year)

Severna Park, Maryland

31 Robinson Road

32. Digistrar's Signature

Wesley 6	الادا	rye Brime Jr. Please Typ	oe or Print in	n Black Inc	delible Ir	nk. Ensure	All Cor	oies Are Le	gible.		
UNK UNK		St 1- For State Registrar	ate of Maryla		rtment of tificate of		d Mental	, g	2 (Reg. No.	007 34	11
Physicia	an/	Decedent's Name (First, Midd	le,Last)					2. Date of De	ath Dav Year	3. Time of Deatl	ih
Medical Exami	ner	Wesley Geo	orge Bowne	Jr.		4b. City, Town, or	ocation of De		Day Year er 27, 2007	1815 hrs	
		Patuxent River Road	on, give sileet and no	imber)		Crownsville	Location of De	Saur	Anne Aru		Ì
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year			irth(MM/DD/YYYY)	g. Birthplace (State or Foreign	
Director		117-54-4973	1 <b>XX</b> M 2 F	45	Yrs	Months Days	Hours	Min. 11/02	/1961	Country New Yo	ork
any		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Locati	ion	_			10d. Inside City	
	L	Maryland Anne A	Arundel	Crof						1XX Yes 2	
larylan Sa-f s	Director	10e. Street and Number		-		10f. Zip Code			10g. Citizen of What	at Country?	
vith the Maryland s 23a or 28a-f show s notified at once.		1700A West Bar	ncroft Lan	.e		2111	4		U.S.A.		
th with	Funeral	11. Marital Status 1 XXever Married 2 M	12. Was Dec	cedent Ever in U.Sorces?		s Decedent of His			lo- 14. Race White	- American Indian, Black , etc.	k,
er dea			1 Yes	2 X No		Yes 2 X No		,	Specific	White	
ours aft	d by	15. Decedent's Education (Spe	or Dates:		16a. Deceden	it's Usual Occupat	on (Give kind		16b. Kind of Bus		
6 172 ho an "na cal Ex	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	•	ost of working life.		·	0.16		-
003 within giene.	dmo	17. Father's Name (First, Middle	2		Furnit	ure Rest			Self , Maiden Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		,	•			1		ia McMan	·		
21; ould b d Men s marlic eve	To	Wesley George 19a. Informant's Name/Relations	ship (Type, Print)	•	19b. Mailing				umber, City or Town	ı, State, Zip Code)	
MD nd 2 sho alth and m 27 is		Patricia McMar	us/Mother					Lane, Co		laryland 21	114
Ore, es la of He If ite		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal fr	om State Our	rematory or otl	sition (Name of cer her place) Of The F	ields	Date	206. Location -	City or Town, State	
Baltimore, oermit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Services	, ,	Cat	holic	Cemetarv	110	0/08/2001	7 Millers	ville,Mary neral Home	1and
Ba perm Depa Impo		21. Signatur of Pullbar ervice	Licensee							land 20715	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death.							
/Medical caminer		Immediate Cause (Final disease	<sub>a.</sub> Hanging							Death	
		or condition resulting in death)	Due to (or as a	a consequence of	):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence of	):						
	caminer	(Disease or injury that initiated events resulting in death) Last	C.	a consequence of	):						
ecuted and transit	al Ex		d								
0, be excision sician	edic	UNPENDED	AMENDED								
Box 68760, death certificate be execut the attending physician and of for use as the burial - tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?		outcome of pregr pirth		etal death 3	Ectopic pre	egnancy	23d. Date of Month	-	ear
OX 6 ath cer attendi	sicia		transver   '=	nant at time of dea	ath 5 Ot	ther (Specify)					
O. Bo nat the de d by the	Phy	Part II. Other significant condi	9 Unkn		esulting in the u	underlying cause g	iven in Part I.	23e. Did	tobacco use contri	bute to the cause of dea	ath?
tal Records, P.O. B cian: The law requires that the de certificate has been signed by the ector, page 2 should be detached it	d by							_ 1 _ Y	es 2 🗸 No 3	Probably 4 Unk	known
of Vital Records,  ng Physician: The law require  the this certificate has been si  neral director, page 2 should b	Completed							24a. Wa		Vere autopsy findings a	
Recc The lavicate ha	omb			· · · · · ·	· · · · · · · · · · · · · · · · · · ·					leath? ✓ Yes 2	No
ital Fician: Secretification, precedent, pre	Be C	25. Was case referred to medica examiner?					of Death (Ch				
1 Of VI fing Physic After this	욘	1 Yes 2 No 27. Manner of Death	Hospital: 1 28a. Date		ER/Outpatient 28b. Time of I		Other <sub>4</sub> No	ursing Home 5	Residence 6 e how injury occurr		
on on on on the function	tion:	1 Notural	ding FOUND	n, Day,Year) ):	FOUND:		∕es 2 ✓ No	Subject ha			
Division tal or Attendir rs after death. al Director: A	ificat		estigation Sep 27.  28e. Place		1819 hrs me, farm, stre	et, factory, office t	uilding, etc.			er or Rural Route Numb	per, City
Divi spital or . lours after neral Dir filled in l	Certification:	4 Homicide dete		Woods				or Town Patuxent Ri	ver Road, Crown	sville, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	edical	(Oneon only	Physician: To the beaminer: On the basis	of examination ar							
To vitt	Med	29b. Signature and title of certifi	and manner s	stated.		29c. Licens	e number		29d. Date sign	ed (Month, Day, Year)	-
Office of the state of the stat	Y	Tousha!	Jeef h	ip		O.C.	M.E.		September	28, 2007	
146		30. Name and address of person Tasha Greenberg MD	A opiotant N	se of death (Item		Penn Street,	Baltimore,	MD 21201			
	ate		0 2007 32.5	gistrar's Signatu		and a					
Regis	trar	UCI U	9 2007	VENU )	5 19						<del></del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Day **Physician** Pramila Jayantilal Baxi 8 2007 7:23 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 812 Wellesley Ct. Carroll Hampstead 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/15/1918 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 214-73-1109 1 □ M 2X F 89 Director India Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than mat be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director Maryland Carroll Hampstead 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 812 Wellesley Ct. 21074 India Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Asian Indian ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jayantilal Baxi Kusumanjari Baxi ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sourabh Munshi - son-inlaw 812 Wellesley Ct., Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/9/2007 Hampstead, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home, 934 South M001490 Main Street, Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aostic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a conse punce of): Examiner law requires that the death certificate be executed Los i com for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 □ Yes No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has | autopsy page performe 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 🔲 Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient 5 Residence 6 Other (Specify) hours after death. uneral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who co

OCT

0 9

2007

31. Date filed (Month, Day,

cause of death (Item 23a) (Type, Print)

32/Begistrar's Signature

3848

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 11:42p M William S. Bard Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director 221-14-0358 83 9-19-1924 PA Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director MD Cecil 1881 Telegraph Rd., Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 21911 1881 Telegraph Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ ★ es 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Š 3X Widowed 4 □ Divorced Year or Dates: WWII White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. int: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Assemblyman 12 Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Bard Swinhart Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Miller 2911 Lincoln Hwy E. Gordonville, PA 17529 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 10-10-2007 4 Donation 5 Other (Specify) Union Cemetery Kirkwood, PA 22. Name and Address of Facility Edward L. Collins Funeral 21. Signature of Funeral Service License Home, Inc. 86 Pine St. Oxford, schard PA 19363 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part . Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final AINCOL Physician tred disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) burial attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2010o certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division or Vital Records, within 24 hours after accu..

To the Funeral Director: After this To the Hospital

> I VA State Registrar

BRAMAN 31. Date filed (Mo.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BUN 32. Registrar's Signature

DUDY ME

CECIL COUNTY

29c. License number

>

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Bailey Wulf Lenore /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner NICOMICO KEGIONAL ALISBURY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs. New York Director 4-21-1926 218-20-3047 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Eden MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21822 25477 Harcum Wharf Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Publisher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chesta Cordelia Reed ပ Hubert H. Wulf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 723 Camden Avenue, Salisbury, MD 21801 Buxton Reed Bailey - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 10-9-2007 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Ligensee 705 E. Main Street, Salisbury, Maryland 21804 flications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence if **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 NO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 2 No certificate 1∐ Yes Director: After this certific in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital 1 Hipatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 D Mattural 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

Maryland 21215-6036

Baltimore,

To the Hospital within 24 hours a To the Funeral D

State Registrar

Medical

29b. Signature and title of certifier dren

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Oct. 5, 2007

MD. 21804

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

1346 S. DIVISION ST. SALISBURY WENRICH

31. Date filed (Month, Day, Year) 0 9 2007 OCT

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

ROOMEY



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Jane Ophelia Bass 1220 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death cility Name (If not insti**r0**tion, give street and Examiner NICOMICO ENINSULA EGIONAL ENTER DALISBURY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 □ M 2 🔀 F 82 411-32-0480 Director Tennessee 7/10/1925 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 No Director notified Ingham Michigan Okemos 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with a or USA 48864 2040 Shaqbark 23a "natural", or items 23s edical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Stewart James C. harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26018 Rebecca, Brownstown, MI 48134 Cheryl Frost/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/06/07 Glendale Cemetery Okemos, Michigan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kert 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Du to s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician 6 Physician/Medical the as attending IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown by signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate ! 2 No 2 No 1 ☐ Yes Division or Vital Physician: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending Patter death. After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely

State Registrar 29b. Signature and title of certifie

30. Name and address of person

JOSEPH

9ª 2007

29c. License number

1)2044

100E CARROLL ST. SAlisbury MD. 21801

29d. Date signed (Month, Day, Year)

and manner stated.

CAETTO

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

MU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. STATE OF MATEMATO DEFATHER 7 St 1847 40 7 Wental Hygiene 007 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18, 2007 CAROLYN FRANCES CANOVA Oct. 6:42 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air | H Under 1 Year | H Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Hours | Min. | 7 / 4 / 1 9 / 16 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 277 F 212-48-5183 61 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or iteme 23s or 28e-f ehow 1 Yes 2 No Be Completed by Funeral Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 North Furnace Road United States 21084 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 end 2 should be filed within Health and Mental Hygiene. em 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife 17. Father's Name (First, Middle, Last)

Gardner

Fran 18. Mother's Name (First, Middle, Maiden Sumame) Francis Gonyo Verna Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) John T. Canova (Husband) 3407 North Furnace Rd. Jarrettsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ō Jarrettsville Cem. 10/23/07 Jarrettsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MGO Cardial INFARCTION Immediate Cause (Final **Physician** MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit the death certificate be executed Rhoungale Due to (or as a consequence of): attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death NA 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERTENSOON STAGE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed restruc sicep 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Obstructive performed? (es 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 R/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To .pis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred NA Hospital or Attending 1 Natural 2 ☐ Accident s effer de. ral Director: Alte 5 Pending 1 ☐ Yes 2 ☐ No investigation NA 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide NA within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10017679

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Baltimore,

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Division of Vital Records,

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pb 138× 216

32. Registrar's Signature

AGARY H ESIACASTE, MAD

31. Date filed (Month Day, Year) 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 3,300 Physician Hobe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner nshington Theran Village myenwood 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 7. Age (In yrs. last birth 5. Social Security Number 6. Sex **Funeral** Months 92 Days Hours 1□M 2 F 223-05-3355 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State show "natural", or Items 23a or 28a-f shoved at examiner must be notified at 1 Yes 2 No Hagerstown Director MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 1183 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: (1) nit Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Inope. 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ( 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 Old national Hagerstown MD 21740 Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition washington Memorial oct 19 2007 Sandston 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Fred L. Vestal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 's ease 34-cars **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): the attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day page 2 should be detached for i in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes □ No 24a. Was an has autopsy 2 No this certificate 1∏ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 200 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, completely filled in by the funeral within 24 hours after deatl To the Funeral Director:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

24

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Ifm 23a) (Type, Print)

MAN241. DS H4H 368 "NUU! Steelnull 32: Registrar's Signature Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

1

3 ☐ Suicide 4 Homicide

31. Date filed (Month,

Amend Item # 1 & 2 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For County Health Dept 10/22/07 Figure Registrar County Health Dept 10/22/07 Figure Registrar Reg. No. 8 Cecil Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lorenzo Antonio Santiago ZW **Physician** Month 0 Day Carrillo 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMALE MAKY LAND nivacity UX If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 760 1**X**M 2□ F Months Mexico Director 142-87-0214 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director <u>Delaware</u> <u>New Castle</u> Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 1917 W. 6th Street 19805 Funeral 12. Was Decedent Ever in U.S. Armed Forces & 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Maryland 21215-0036 white 1 XYes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Roofer Construction permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 Is marked other 1 any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvino Carrillo Laurentino Santiago ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Newark, Joyce Hindsley 36 Millbrook Road DE 19713 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Municipal San Jose, Mexico 21. Signature of Fun ral Service License 22. Name and Address of Facility Corleto Latina Funeral Tome Wilmington, DE 19805 808 N. Union St. 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Day Year 5 Other (specify) the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 X/Vo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate performa director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Hopatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this funeral dir Mayner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 106 20. Name and address of person whol completed cause of death (Item 23a) (Type, Print) SNA Warne 87 31. Date filed (Month, Day, Year) QCT 2 2 2007 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Reginald F. Celestin 2007 October 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chever1y

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Prince George's Hospital Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 € M 2 ☐ F Months 436-74-0305 61 Oct 11, 1945 New Orleans, 10b. County 10c. City, Town or Location 10d, Inside City Limits 1√2 Yes 2 □ No Maryland Prince George's <u>Mitchellville</u> 10e. Street and Number 10g. Citizen of What Country? 11302 Indian Wells Lane 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 157 Yes 2 □ No If Yes, Give Year or Dates; 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 3 Vears Assistant Sales Director Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Earl Celestin Irma Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Celestin - Spouse 11302 Indian Wells Lane Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Mem. Park Oct. 13, 2007 Landover, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of). Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 a Department of Health an Important: If Item 27 is any Injury or other trau

Physician

/Medical

Examiner

Director

Funera

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Completed

Be ျှ 10a. State

**Funeral** 

Director

Baltimore, Maryland 21215-0036

page 2 director,

The law requires that the death certificate be executed

Hospital or Attending Physician:

death,

within 24 hours a To the Funeral I

completely

Medical

Division or Vital Records, P.O. Box 68760.

Examine attending physician for use as the buris Physician/Medical Completed by certificate Be Certification: To this filled in by the funeral after death

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ☑ER/Outpatient 3 ☐ DOA 1 🗆 Innatient 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print)

State

Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

		State of Maryland / Depa		ental Hygi	ene	
		1109101141	rtificate of Death		g. No 2007	34123
Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	28 2007	3. Time of Death 6:45P M
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Lxaninie		79 Jones Station Rd	Amold		Anne A	-rundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  2.1.6 1.9 5.2.7.1    1.▼ M 2□ F    2.2. Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)   Cou	place (State or Foreign intry)
Director	-	216-18-5271 XIM ZLIF 83 Yrs.  Usual Residence of Decedent		July 7	1924 Mar	yland
yland now at	-	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
e Mar ta-f st	ر ا و	Maryland Anne Arundel Arnold				1 ☐ Yes 2√∑ No
or 28	5 I	10e. Street and Number	10f. Zip Code	10	ng. Citizen of What Cou	intry?
s 23a	era L	79 Jones Station Rd.  11 Marital Status 12. Was Decedent Ever in U.S. 13. 1	21012	oifu Von or No	USA 14. Race - Ameri	ican Indian
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21215-0036  24 within 72 hours after death with the Maryland gliene.  er than "natural", or Items 23a or 28a-f show, the Medical Examiner must be notified at	o	3 ☐ Widowed 4 ☐ Divorced If ₹es, Give Year or Dates: 1943-46	1 ☐ Yes 🌠 No Specify:		Specify: B1	ack
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Maryland nd 2 should be file lith and Mental H. 27 Is marked oth r traumatic eveni		19a. Informant's Name/Relationship (Type. Print) 19b. Mailir	ng Address (Street and Number or Rura	l Route Number,	City or Town, State, Zi	ip Code)
and and marking markin			ones Station Rd			
MOCK Pages 1 nent of H nut: If Ite Iny or ot		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		20c. Location - City or T	
	-		d Veteran 10-4 mvameReese of Eacil Bons		Crownsvil	le, Md.
Balt permit. Departi Imports any Inji			21 West St. Ann		-	01
1.5		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or he int failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	4			Onset and Death
/Medical Examiner	1	resulting in death)  Due to (or as a consequence of):				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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uted d ansit	Examiner	Cause (Disease or injury				
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit	dicai	d				
x 6	Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy				
Records, P.O. Box 6 The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deli-	very Day Year
the d	JASI	1 ☐ Yes 2 ☐ No 9 ☐ Unknown				
S, D	Dy PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Vital Records, ldan: The law requires t certificate has been signe ector, page 2 should be	Completed	<u></u>		24a. Was ar autops	v I prior to c	topsy findings available ompletion of cause of
al F				perform 1□ Yes 3	ned? death? No 1 ☐ Yes	2 <b>X</b> No
vision or Vita Attending Physician: rdeath. ector: After this certific by the funeral director,	ne ne	25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatier	26. Place of Death	1	e) nce 6 □Other (Spec	
g Phy g Phy er this	0	27. Manner of Death 28a. Date of Injury 28b. Time o			w injury occurred	ary)
sior endln eath. or: Aff	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division or or attending Phys after death.  Director: After this i in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
Hospital of Funeral Estely filled i		29a. Certifier 1 ertifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the co	auea/e) and mannar ac	etatod
	edical	(Check only one)  2 dedical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
To the within To the comple	ğ	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Month	ı, Day, Year)
		M MS	DW6457	7	10/4/07	
		30. Name and address of person who completed cause of death (Item 23a) (Type,	1 11 1 2 1	00 A	ali Mo	214.0
Stat	9	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	Touch Re Jure 5	HAN	apalis in	&LTU1
Registra		OCT 0 9 2007	book			

	d)		1. Decedent's Name	(First, Middle, Las	st)							2. Date of D				3. Time of Death
	Physici /Medic		Holl	y M. Clal	baugh							Month Octobe	Day 8	, 20ď	7	9:35p M
	Examir		4a. Facility Name (If	not institution, give	e street and number	er)		4b. City, To	n, or Lo	ocation of		OC LODE		County of I	Death	
			Fred	erick Mer	morial Ho	spita.	1	Fre	der	ick				Frede	orio	nle
	Funeral	٠.	5. Social Security Nu	umber 6. S	ex 7.	Age (In yrs.		If Under 1 Y	ear I	f Under 2		8. Date of B	irth	0	Birthpl	ace (State or Foreign
- 11	Director	i	214-46-58	339	□M 2TF	60	Yrs.	Months D	ays	Hours	Min.	ec. 2	7, Year)	46 M	Count	Tand
	p		Usual Residence of							-						
	rylan how Lat		10a. State	10b. County		10c. City	y, Town or Loc	cation							10	Od. Inside City Limits
	a-fs	턍	Maryland	Frederic	k	r	hurmon	t								1 □ Yes 2 □ No
	or 28	ire	10e. Street and Num	nber				10f. Zip Co	de				10g. Citiz	zen of Wha	t Count	try?
	leath with the Marylan ns 23a or 28a-f show must be notified at	Funeral Director	6913 Ke11y	Store R	.oad				2178	38				U.S.	Α.	
	ems er mi	iner	11. Marital Status		12. Was Decede	ent Ever in U.	S. 13. V	Vas Deceden Yes, specity	of Hisp	anic Orig	in? (Spec	city Yes or N	10-	14. Race - A		
9	after or it		1 Never Marrie	_	Armed Force 1  Yes 2	Νo		□Yes 2K		Specify:	, , , , , , , , , , , , , , , , , , , ,			Specify:	vinto, t	510.
93	ours iral", Exa	d by	3 Widowed	4 Divorced	If Yes, Give Year or Date	es:								Specify.	Wh	ite
5-0	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be Completed	(Speci	15. Decedent's Edify only highest gra	lucation ide completed)		16a. Deced (Give	ent's Usual C kind of work o OO NOT use r	ccupati one dui	on ring most	of workin	g	16b. Kir	nd of Busin	ess/ind	lustry
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2	ygie ygie rer tl	ខ	12	=			кеа	1 Esta				/=:		eal E	sta	te
n P	be fill hall hall hall hall hall hall hall h	Be	17. Father's Name (A	*					1			(First, Middle		Surname)		
<u>\sq</u>	ould Mer narke	욘					T					e Seij				
Jar	2 sh n and is m raum		19a. Informant's Na					g Address (S								Code)
4	and lealth m 27		Don L. C1		ниѕрапа	Taok 5		Kelly				ate				
o G	ges 1 t of F if ite or ot		20a. Method of Dispersion 1 Burial 2	osition Cremation 3	Removal from Sta	11.E I	lace of Dispos emetery, cren						20c. Loc	cation - Cit	yorlo	wn, State
Ë	men tant: jury		4 ☐ Donation	5 ☐ Other (Specify	y)	B1u	e Ridg				)/12/			-		ryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner.		21. Signature of Fur	neral Service Licer	1500	2 2	RQ:	Name and A	ddress DA	of Facility	& <u>S</u>	ON FUI	NERAL	НОМЕ	S, 1	P.A.
	E0 = 10 O		Soft	EU S	* Lail	41	/ 61	5 EAST	MAI	N ST	., T	HURMOI	NT, M	D 217	88	
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y.	Physician		Immediate Cause (F disease or condition resulting in death)	Final 1	a. Con	ndidal	Sap si									
	/Medical Examiner		resulting in death)	- (	Due to (or	as a consequ	uence of):									1
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	ecut and I-tran	xan	that initiated events resulting in death) Li		C	as a consequ	uencedi):	, W:	yn	una					_	Mann
Box 68760,	eath certificate be executed affending physician and for use as the burial-transit	cian/Medical Examiner		· ·	240 (0)	40011004	adiles 41).	·								
87	phys:	di		•	d										_	
×	certifi ding se as	/Me	IF FEMALE:		23c. If yes, outcome	me of pregna	ancv							20-1 D-1-		
Bo	eath ( aften for u	ian	23b. Was decedent in the past 12 i	months?	1 ☐ Live birtl		Ideath 3□	Ectopic pregr Other (speci	ancy				2	23d. Date o Month		ry Day Year
Ö	the d	Physic	1□Yes 2☑ 9□Unknown	žNo	9 Unknow		eau 5_	Tottler (speci	y)							
P.0	w requires that the d been signed by the should be detached	P.	Part II. Other signifi	icant conditions	ontributing to deat	h but not resi	ulting in the un	derlying caus	e given	in Part I.		23e. Did	tobacco us	se contribu	te to th	e cause of death?
ds,	signe d be	j by	Mi	tabelic	Audos	2						1	Yes 2	No 3[	Prob	ably 4 □Unknown
Ö	requ	Completed	D	1 [	20	-01										
ec Sec	e faw has l	ldu	Ke	mal To	ayure							24a. Wa	s an opsy formed?	24b. Wei	re autor	osy findings available npletion of cause of
<u>=</u>	: Th cate , pag	S										1□ Yes		1	Yes	2□ No
Vita	Iclan Sertifi Sector	Be	25. Was case referrexaminer?		Hospital:						of Death	(Check only	one)			
or.	Attending Physician: The law requires that the death certificate be executed refath. ector: After this certificate has been signed by the aftending physician and by the funeral director, page 2 should be detached for use as the bunal-transit	은	1 Yes 2		inp		ER/Outpatien		Other:	4 LI Nur		ne 5 Res			Specify	()
n c	ling I	on:	27. Manper of Death 1 Matural	5 Pending	28a. Date of I (Month,	Day Year)	28b. Time of Injury		Injury a Work?			8d. Describe	how injury	y occurred		
Sic	tend leath tor: the f	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be				M		s 2 🗆 N		00 1 1	(2)			
Division or Vital Records,	or At offer d Direct in by	Certification:	4 Homicide	determined	Zoe. Place of	, etc. (Specify	ome, farm, stre	eet, ractory, o	tice		2	8f. Location City or To	(Street and own, State)	d Number ( )	or Hura.	l Route Number,
11	pital ours eral filled		29a. Certifier	1 Certifying Ph	vsician: To the be	est of my kno	wledge death	occurred at t	he time	date and	d place a	and due to th	e cause(s)	and mann	ar as st	ated
	e Hos 24 h e Fun letely	Medical		2 Medical Exam		is of examina										
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and	title of certifier				29c. L	cense r	number	_		29d. Date	e signed (I	Nonth, I	Day, Year)
			N	, Kaz	D1			D	61	166			10	2/8	- /	07
,	(Tr		30. Name and addre	ess of person who	completed cause of	of death (Item	1 23a) (Type I	- 1	- 0	•			, ,	- [ 0		- (
	D		Mudyso		Annie .		Meron		ND	7	4	treet	Fre	duck	l	10) 31701
			21 Data filed (Mant	th Day Veer	32 Pen	ietrar'e Sinna	ture	- rue	iu -	(_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	) /	2-01		117 -117-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1

ate of delivery **donth** Year Day ntribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No ther (Specify) nber or Rural Route Number, manner as stated. e, and due to the cause(s) ned (Month, Day, Year) Mi) 31701 OCT 1 1 2007 Steen & Speck **ORIGINAL** 

Registrar DHMH 17 Rev 1/2001 1 - For State Registrar

07-07790 John Caše

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

n Case		I- For State	State of Maryland		ficate of		intai riyg	Reg. I	No. 20	107 3412
Physici	an/	1. Decedent's Name (First, I		0	Tee			Date of Death Month Da	ay Year	3. Time of Death 0232 hrs
~~al Exami		John	Franklin titution, give street and number	Case		4b. City, Town, or Location		October 6, 2	4c. County of De	
		Peninsula Regiona		,		Salisbury			Wicomico	
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	birthday)			8. Date of Birth(	For	Birthplace (State or eign
Director		091-62-1278	1 X M 2 F	42	Yrs		urs Min.	06/13/1	.965	Country) Ohio
S.	ļ	Usual Residence of Deceder 10a. State 10b. Co		10c City To	own or Locat	ion				10d. Inside City Limits
ow any			ŕ							1 X Yes 2 No
ryland sa-f sh it once	çç	Maryland W 10e. Street and Number	licomico	Sna	rptow	10f. Zip Code		10g.	Citizen of What C	ountry?
ith the Maryland 123a or 28a-f show a notified at once.	Director	406 Railway	Street			21861			USA	
with 1 ms 23; be not	era	11. Marital Status	12. Was Deceder		13. Wa	as Decedent of Hispanic C es, specify Cuban, Mexic	Origin? (Spec	cify Yes or No-	14. Race - An White, etc	nerican Indian, Black,
r death or ite must	Funeral	1 Never Married 2	1 Yes 2	2 X No		Yes 2 X No speci			Specify:	white
rs afte ural", miner	ğ	3 Widowed 4 15. Decedent's Education	Divorced If Yes, Giva Year or Dates:  (Specify only highest grade co	ompleted) 1	6a. Deceder	nt's Usual Occupation (Given	ive kind of wo	ork done 1	6b. Kind of Busine	
72 hou n "nat al Exa	Completed	Elementary/Secondary (			9	nost of working life. DO NO		d)		
5-0036 iled within 7/ Hygiene. I other than the Medical	du	12	4		loca.	l general ma	_	First, Middle, Ma		Home Sales
15-0 filed v I Hygi d oth	ပိ	17. Father's Name (First, M								
2121 ould be fi Mental I marked	To Be	John Franki 19a, Informant's Name/Rela	in Case, Sr.		19b. Mailin	g Address (Street and N	Number or Ru	ral Route Numb	nC1SO er, City or Town, S	tate, Zip Code)
MD 2 d 2 shou lith and 1 m 27 is a	-	Catherine A	nn Case/wife			Railway St,			ID 21861	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygiene.  Intel. If item 27 is marked other than "natural", or items 23a or 28a-f shown with traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Bunal 2 Crei		State Cre	ematory or o	sition (Name of cemetery, ther place)			20c. Location - Cit	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiera. Important: If tiem 27 is narked other than injury or other traumatic event, the Medical	_	4 Denation 5 Oth		Ma	rion	Cemetery		/13/07	Marion	Ohio
Salti ermit. Departi mport		2. Signature of Funeral 9	ervice Licensee	0500	22.	Name and Address of Fac Holloway Fun	neral E	Home Pro	fessiona	l Association
-Physician	_	23a, Part I. Enter the disea	ervice Licensee	ed the death. I	Do not enter	OOL Snow Hill the mode of dying, such a	as cardiac or	Salish respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Medical	1	failure. List only one Immediate Cause (Final di	cause on each line.			ırkitt's Lympho				Death
_xaminer		or condition resulting in de								
	<u></u>	Sequentially list conditions if any, leading to immediat		nsequence of)	:					
	Examiner	cause. Enter Underlying ( (Disease or injury that initi	Cause c.							
ted I	Exa	events resulting in death)		nsequence of)	:					
(ecords, P.O. Box 68760, he law requires that the death certificate be executed are has been signed by the attending physician and are 2 should be detached for use as the burial - transit	Medical	X UNPENDED		c87/L 1	2/5/07	TT/ #23a,27,pe	arME o87	4 12/11/		
760, cate be	Med	IF FEMALE:	23c. If yes, out	come or pregn	ancy				200. Date of de	
687 certifi	ian/	23b. Was decedent pregna past 12 months?	I LIVE BITAT	at time of dea	- =	etal death 3Ec	ctopic pregnar	ncy	Month	Day Year
Box 687 death certifice the attending perforuse as the	Physician/	1 Yes 2 No 9	- J Olikilowii						<u> </u>	
P.O.	by PI		conditions contributing to de	eath but not re	sulting in the	e underlying cause given i	in Part I.			te to the cause of death?  Probably 4 Unknown
S, P luires t in sign Id be c	pa							24a. Was a		re autopsy findings available
cord aw req	plet							autops perform	sy prio m <u>ed</u> ? dea	or to completion of cause of other
0220	Completed					26.Place of De	eath (Check (	1 Yes 2	No 1	Yes 2 No
of Vital Records, ig Physician: The law requir ther this certificate has been some different mare 2 should li	Be		Hospital:	atient 2	ER/Outpatie	Other			Residence 6	Other:
n of Vir ling Physic After this		27 Manner of Death	28a. Date of (Month, Da		28b. Time o	f Injury 28c. Injury at V	Work?	28d. Describe h	ow injury occurred	
_ <u>=</u> _ ~ @	ig io	1 X Natural 5	Pending Investigation	2,,,,,,		1 Yes 2	2 No			
Division tal or Attendi rs after death al Director:	iji	3 Suicide 6	Could not be 28e. Place o	of Injury - At ho	me, farm, st	reet, factory, office building	ng, etc.	28f. Location (S or Town, S		or Rural Route Number, City
Division of Vital    Bispital or Attending Physician: 24 hours after death Funeral Director. After this certif			determined (Specify)  fying Physician: To the best o	f mu lumqual qui	a dooth oo	oursed at the time, date as	nd place, and	I due to the caus	e(s) and manner a	s stated.
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only 1 Certification) 2 Medic	rying Physician: To the best of cal Examiner:On the basis of and manner state	examination a	nd/or investi	gation, in my opinion, dea	ath occurred a	at the time, date	and place, and due	e to the cause(s)
of wit	Me	29b. Signature and title of		eu.		29c. License nun	mber			(Month, Day, Year)
D.		Allina	Brasse Ci	111)		O.C.M.E			October 6, 2	007
E.			person who completed cause			Penn Street, Baltir	more MD	21201		
V	C/-/	Melissa Brassell 31. Date filed (Mont) Per		cal Examir krar's Signatu		T CHI SUCCE, DAILI	more, MD			
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OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 Cholewczynski Edmund /Medical County of Death acility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner 15burs 101MICO Regions 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 215-30-6014 73 Director 11/22/1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notifled 1 X Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò **23a** Funeral 1514 Riverside Dr., Apt. C302 21801 USA Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced white "natural" Completed other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. n/a disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Cholewczynski Julia Eva Bartkowiak 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other traconce. Gail McClymont/executor 108 Justice Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 10/8/07 4 □ Donation 5 □ Other (Specify) Salisbury, MD Park HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 24 tarre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ONONANY BRIEM DISEASE 4 EANS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner he law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician ise as the buria Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEMSE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of rector, page 2 s autopsy perform death? 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

ss of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

MI

2007 5

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D*38353* 

100 EAST CAROLL ST. SAlisbury Md 21801

34127 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 17, 2007 John Edgar Dorsey 9:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08–08–1921 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 218-12-2956 86 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County fshow 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD Calvert Solomons 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11450 Asbury Circle, Apt. #236 20688 United States Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White \$ WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Department of US Navy <u>Procurement Specialist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H John William Dorsey Clara Mae Ripley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If Item 27 is Veda L. Dorsey (Wife) 11450 Asbury Circle, Apt. #236, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If I
any injury or 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 10/18/07 | Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service License Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant atter for u 3 ☐ Ectopic pregnancy Year in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has b autopsy performed death? 1 ☐ Yes 2□ No 2**X** No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident irector 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0052242 October 17, 2007

Registrar

32 Registrar's Signature

31. Date filed (Month, Day, Year) NCT 2 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



J. John Barth, III, M.D. 14090 Solomons Island Road, Suite 2500, Solomons, MD 20688

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit 124 hours after le Funeral Dire pletely filled in b within 24

											24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25	Was case referre	ed to medical						26.	Place of Dea	th (C	Check only one)	
	examiner? 1 ☐ Yes 2	No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home						me 5 Residence 6 Other (Specify)			
27.	Manner of Death Natural 2 Accident	5 Pending investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1  Yes	2 □ No	280	d. Describe how injury	occurred
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		28e. Place of injury - At h building, etc. (Speci		et, fact	ory, of	fice		28f	Location (Street and City or Town, State)	l Number or Rural Route Number,
29				cian: To the best of my knoer: On the basis of examina								and manner as stated. place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

39 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, um 2140)

31. Date filed (Month, Day, State

and manner stated

OCT 0 9 2007

Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0ct 2007 ALPRED DENNIS 0.3 /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ENINSULA KEGIONAL MEDICAL CENTER Nicomico PALIBURY If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours Min. 1 X M 2 □ F 214-16-4085 Director 87 July 11, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director Maryland Wicomico Eden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with n and Mental Hyglene. USA 26561 Collins Wharf Funeral Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th J. Roland Dashiell & Son truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Winifred Beatrice Polk Robert Wayne Dennis. Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

Date Gwendolyn Dennis/wife 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship UMC Cemeterv10/8/2007 | Allen, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Sign Jure o Funeral Service License 21801 JOLLEY MEMORIAL CHAPEL, P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one/cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner 7 5 YRS CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed (AROIOMYOPATHY burial-trar Due to (or as a consequence of): P.O. Box 68760, physician 5/P ASCVD the attending place as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 1 Yes 2 No 4 ☐Unknown DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RENAL INSUFFICIENCY 24a. Was an page 2 s autopsy certificate | COPD 1∐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyer of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only completely within 24 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 050929 0-3-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DIVISION ST.

SAUSBURY

1405

MADARANG - LEWIS

5.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JAMES RILEY ELSEY 27, 200 7 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Social Security Number 6. Sex, 7. Age (In pr. last birthday) Salisbur Wicomico If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 4-16-1930 **Funeral** Months Days Director NC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 2545 HICKMAN 1 ☐ Yes 2 No Director WICOMICC 10e. Street and Number log. Citizen of What Country? 10f. Zip Code by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BL Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No 3 Widowed 4 ☐ Divorced ACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAFCOT ATERMA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WRIGHT ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3545 Hickman Un 10 Histicoke, IMD 21840 GARY ELSEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State NANTICOKE CEMETERY 4 □ Donation 5 □ Other (Specify) MANTKOKE, MED 21. Signature of Funeral Service Licenses 22. Name and Addre Name and Address of Facility Funeral Hame 31814 Fenn MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Krown /Medical Due to (or as a consequence of) **Examiner** oan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last U Physician/Medical Examiner Due to (or as a consequence or) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician for use as the burial IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | 1 | No 2 ER/Outpatient 3 DOA မ 1 Inpatient after death.

I Director: After this d in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Defitiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sins, M.D. H. Villiam Rot NVIC lisbury OCT Registrar's Signature State 9

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Donald Elijah Fardan $p^{M}$ Oct 2007 4:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hosp. Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/28/1940 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days 1 X M 2 □ F 577-54-6427 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 XNo Montgomery Dickerson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 18901 Martinsburg Rd. 20842 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician/ Singer 5+ Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Obie Dorsey Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Blake Fardan-wife 18901 Martinsburg Rd. Dickerson, Md. 20842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/07 Martinsburg Comm. Dickerson, Md. 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Universal 411 Kennedy St., N.W. Washington, DC 20011 Wart 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) preumonia piration Z weeks Due to (or as a consequence of): ears tastatic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bilster pleural 1 🗌 Yes 2 No 3 Probably 4 Unknown oniz Obstructive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No autopsy 25 Was case referred to medical examiner? hrembosis 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Md.

Director

Funeral

Completed by

Be

P

Examiner

**Funeral** 

Director

show r 28a-f sh notified

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be It

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Records,

Vital

0

with the Maryland

Examine

Physician/Medical

Completed

Be

2

burial-tran physician the as nse for signed by page 2 s certificate has director this

that the death certificate be executed After death.

0 Registrar

Certification: Division Hospital or Attending 124 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely. Medical completely the State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

29c. License number D0053654

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Hospital:

medical Center Drive, Rockville, mo 20850 21-11 440

filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
10/17/07 Cartificate of Death State Registrar Amended 28e &f per Phy, gc Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 4, 2007 11:35a <sup>™</sup> Flores Bertilio Miranda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 1** M 2 □ F 26 Yrs. El Salvador Sept.5, 1981 Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified ≈ traumatic. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State X□Yes 2□No Forestville Md. Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3305 Walters Lane 20747 El Salvador Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Maryland 21215-0036 Yes 2□ No Specify: Salvadoran Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Landscape Elementary/Secondary (0-12) College (1-4or 5+) Landscaper permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evangelista Miranda Carmen Valles Miranda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruben Benitez (Brother) 3305Walters Lane Apt. 4 Forestville, Md. 20747 Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2007 Family Cemetery San Miguel, El Salvador Washington 20010 22. Name and Address of Facility 21. Signature of Funeral Service Licensee W. H. Bacon Funeral Home, in 3447 14th Street, 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiral or arrest, shock, or heart failure. List only one cause on each line. W. H. Bacon Funeral Home inc. N. W. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTRACRANIAL HEMORRHAGE disease or condition resulting in death) an O we /Medical Due to (or as a consequence of): Examiner HEAD OSED if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of Box 68760, physician Physician/Medical the as attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy page perform Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ۴ After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 □ Natural 5 Pending -28-07 1 ☐ Yes 2 1No PED STRUCK 2 Accident death. investigation To the Hospital or Attender within 24 hours after death To the Funeral Director. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by STre AVENUE 4 ☐ Homicide MSPEN HILL CONNETIENT NOC HOPEN HILL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October, 10, 2007 17 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BE GEORGETOWN RD OLD 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FLESHMAN **Physician** NORA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Caring Hearts and Hands Assisted Examiner Prince George's Bowie Living Facility 13201 Iris Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2**√**F Months Days Hours 94 214-28-4368 1913 Maryland Director July 3, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Exeminer must be notified at 1 TYes 2 □ No Bowie MD Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 13201 Iris Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or itement in Jury or other trainment. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Marche Florist Elementary/Secondary (0-12) College (1-4or 5+) Floral Designer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary L. Jackson George D. Fenwick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephenson, Virginia PO Box 66 Helen Estep/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial- 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland Fort Lincoln Cemetery 10/13/07 4 Donation 5 Other (Specify) 21. Sign wife of Funeral Service Ligari 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 1101491 238. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dising, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Examine the burial-trai Due to (or as a consequence of). Box 68760, attending physician The law requires that the death certificate be Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day jo in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death P.O. I been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an s certificate hes birector, page 2 s autopsy 1□ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Qther (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the f 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral Completely filled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many stated.

Registrar

32. Registrar's Sign ture

29c. License number

D 21438

em 23a) (Type, Print)
445 PEFENSE HIGHWAY ANNAPOLIS, MON4U)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 20071 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** October 0 01:12 P M Ross H. Foster, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Medical Center Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 01/14/1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Washington, D.C. 70 578-48-7155 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show at 1 Yes 2 No d 2 should be filed within 72 hours after death with the Man th and Mantal Hyglene. 7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Media Examiner must be notifiled. Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20748 5108 Wilkins Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Saltimore, Maryland 21215-0036 Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Automobile** 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Szedlmayer Ross H. Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 ts n any Injury or other traun once. 5108 Wilkins Drive, Temple Hills, Maryland 20748 Sandra Foster/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lakemont Memorial Gardens 10/10/2007 Davidsonville, Maryland 21. Signatur of Emeral Service in 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Abscess **Physician** DAYS /Medical Due to (or as a consequence of) Hepatitis **Examiner** Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Alcoh USE UL attending physician and for use as the burial-trar Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should it Completed 24a. Was an autopsy perforn **≯** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Property Process: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely To the Within 24 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD H0042445 October 7,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 POST OFFICE NOUSD, 1-A WALBOILF, MN ZOGO Z 31. Date filed (Month, Day, Year) State

Registrar

OCT 0 9 2007

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		·	For State Registrar		of Maryla	and / De <sub>l</sub>	oartmen e <i>rtificat</i>	t of He e of D	alth an eath	d Mental H	ygien Reg. N		34136
	Physicia /Medic		1. Decedent's Name (First, MEDGELENE T.	,						2. Date of I	Death Da	4 2007	3. Time of Death
	Examin		4a. Facility Name (If not institute of the control				4b. City,	Town, or L	ocation of D	leath	40	COUNTY OF DEATH	
	Funeral		5. Social Security Number	6. Sex 1 □ M <b>XX</b> F		yrs. last birthda	y) If Under Months	1 Year	if Under 24	Hrs. 8. Date of E Min. (Month, I MAY 2	irth Day, Yea		place (State or Foreign
	Director		237 52 9567 Usual Residence of Deceder		140-	90				MAY 2	8, 19	909 GEO.	RGÍA
	Maryla I-f shov fied at	tor	10a. State 10b. Co	ICE GEORGES		. City, Town or ITCHELL							10d. Inside City Limits 1 ☐ Yes ※X No
	vith the	Director	10e. Street and Number				10f. Zip				_	itizen of What Cor	•
	death v	Funeral	4002 CARIBON	12. Was De	cedent Ever in	n U.S. 13		20721 dent of Hisp	panic Origin	? (Specify Yes or Nuerto Rican, etc.)	I	ITED STA'	ican Indian,
2-110e 5-0036	al', c	þ	1 □ Never Married 2 □  XX Widowed 4 □ Divo	if Yes G	forces? <b>XX</b> No Rive Dates:		if Yes, spe 1 ☐ Yes		Mexican, P	uerto Rican, etc.)		Black, White	, etc. LACK
15-0	in 72 ho i "natur ledical I	Completed	(Specify only h	edent's Education ighest grade completed	<u> </u>	16a. Dec	cedent's Usu ve kind of wo . DO NOT us	al Occupati rk done dui	on ring most of	working	16b. i	Kind of Business/I	ndustry
952	filed withi Hygiene. Ither than	Comp	Elementary/Secondary (0-8TH		(1-4or 5+)		IOMEMAI	ER				PRIVATE	
E(	should be filed nd Mental Hygi marked other matic event, t	To Be	17. Father's Name (First, Mic NEAL TOWNSON					1		Name (First, Midd MOODY	le, Maide	n Surname)	
Mary	ar ar		19a. Informant's Name/Rela							r Rural Route Nun			
7 W	of Health of Health fitem 27		OLIVER GALLO 20a. Method of Disposition		20	b. Place of Dis	CARII			IITCHELLV Date		MD 20	721 Fown, State
70/10 Baltimor	permit. Pages Department of Important: If Its any Injury or o		1XXBurial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Oth	er (Specify)	Juliane	ILEY CE	METER	Z	10,	13/2007		PPLY, GA	
	Depa Impo any I		21. Signature of Fune al Ser	VICE LICENSEE	ll	_	MARSHA 4308	ALL'S SUITLA	FUNEI FUNEI AND RO	RAL HOME DAD SUI	OF M	ARYLAND, D, MD 20	INC. 746
			23a. Par f. Enter the diseas show, or heart failure. Immedia e Cause (Final	e, or complications that List only one cause on	caused the deach line.	leath. Do not e							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a con	equence of):	um	010	12	- 1	1		
ē.	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a cons	sequence of):	escu	kan	æ	ecroten	1		
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a cons	sequence of).							
68760,	icate be executed physician and s the burial-transit	edical E		d	, (o. 20 a com	30que1100 01).							
Box 68		//Med	IF FEMALE: 23b. Was decedent pregnan	, 23c. If yes, o	utcome pf pre	egnancy						23d. Date of deli	
P.O. B	Attending Physician: The law requires that the death carti r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊔Live	birth 2 □ F gnant at time on nown		B⊟Ectopic pi B⊟ Other <i>(sp</i>					Month	Day Year
	signed by	ρ	Part II. Other significant con	nditions contributing to	death but not	resulting in the	underlying c	ause given	in Part I.				the cause of death?
ecor	aw requir s been s 2 should	Completed	Hy	nerter	LSN	)h	7101			24a. Wa		24b. Were au	topsy findings available
al Re	ician: The lav certificate has ector, page 2:		. 0							— au¹ pei 1⊡ Yes	opsy formed? 2D(N	death?	ompletion of cause of 2□ No
× Kit	ysiciar s certif directo	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	2 □ ER/Outpati	ent 3 □ DC	Othor		Death (Check only		S [] ()	***
o no	ding Phy After thi funeral o		27. Manner of Death	28a. Date		28b. Time		8c. Injury a Work?		ng Home 5 ☐ Re 28d. Describ			iny)
Division or Vital Records,	or Atten fter deat Director: in by the	Certification:	3 Suicide 6 □ Co	ould not be 28e. Place	e of injury - A ding, etc. <i>(Spe</i>	At home, farm, s ecify)			5 2 140	28f. Location City or 7	(Street a	and Number or Ru te)	ral Route Number,
		Medical Ce	29a. Certifier Cert (Check only one)	ifying Physician: To th	basis of exam	knowledge, de nination and/or	ath occurred investigation	at the time , in my opir	, date and p	lace, and due to the	e cause( e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within ?	Mec	29b. Signature and title of ce	and ma	nner stated.			. License r				ate signed (Month	
			Thosae	P			7	58	446	)	10/	7/20	07
Cf-1	(3)		Nadehzda	KOVOLCH	UK, M	140 8	118 G	ood L	uck	Rd. La	nhan	n MD	20706
	Sta Registra	-	31. Date filed (Month, Day, 1)	(ear) 32.	Registrar's Si	gnature	,			- <b>-</b>			

State of Maryland / Department of Health and Mental Hygiene. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 07:45 Рм Catherine Patricia Garvey October 0 2ÖÖ7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1□M 2X□F Months **Director** 189-30-7081 68 05/07/1939 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location worde 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23e or 28e-1 ehow any injury or other treumatic event, the Medical Examinar Injury by partitled at once. Maryland Director Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Bridgeport Court 21401 United States Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Walsh Mary B. Banko ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Bridgeport Court, Annapolis, Maryland 21401 Raymond J. Garvey/Husband 20a. Method of Disposition
1 \( \begin{align\*} \text{Disposition} \\ \text{Disposition} \\ \text{2} \end{align\*} \) Bernoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <sup>¹</sup> 4 □Donation 5 □ Other (Specify) Cathedral Cemetery 10-15-07 Scranton, PA 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to fir as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 🗌 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: P 1 Tyes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Mageer of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred **≯** Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours To the Funerel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the limb, date and place, and due to the cause(s) and manner as states.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. mpietely (Check only one) 29b. Signature and title of certifie 29d. Date sigged (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address e c 31. Date liled (Month, Day, Year) 32 Registrar's Signature State OCT 0 9 2007 Registrar

4b. City, Town, or Location of Death

California If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min.

10f. Zip Code

1 ☐ Yes 2X No

20619

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

October |

Date of Birth (Month, Day, Year)

08-31-1921

2007

St. Mary's

4c. County of Death

10g. Citizen of What Country?

USA

9:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2√☐ No

Virginia

14. Race - American Indian,

Oct 12, 2007

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

1 - For State Registrar

Thomas

5. Social Security Number

263-76-5421

10e. Street and Number

10a. State

Maryland

11. Marital Status

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

23114 Crestwood Lane

10b. County

23114 Crestwood Lane

1 Never Married 2 Married

3₺ Widowed 4 Divorced

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

232602

Three

1 8 2007

St. Mary's

Hancock Garth, Sr.

86

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates:

10c. City, Town or Location

California

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Physician /Medical Examiner

sician and burial-tran

within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usua (Give kind of wor.	k done during most of wor		Kind of Business/	Industry
To Be Completec	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT us Surgeon	e retired)	Me	dical_Do	octor
ပ္	17. Father's Name (First, Middle, Last)		Burgeon	18. Mother's Nan	ne (First, Middle, Maide		/CEOI
o Be	James Woods Gart	h		Jane H	ancock	,	
-	19a. Informant's Name/Relationship (Tvi	oe. Print)	19b. Mailing Address	(Street and Number or Ru	ıral Route Number, City	or Town, State, 2	Zip Code)
	Elizabeth H. Garth	,	22260 Bina	vy Mood Cime	la Califor	mia MD	20610
		Daughter	Place of Disposition (Nam	y Wood Circ		Location - City or	
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	1 0	emetery crematory or of	therplace) emetery 10-1.		,	,
	4 □ Donation 5 □ Other (Specify)	2	OO Nome on	d Address of Essilibra			70.4
	21. Signature of Funeral Service Lice Service	110		d Address of Facility Br			
	Edward N.Brinsii				nardtown, N	m 20650	
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deatl e cause on each line.			or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	PROSTATI	R CANCE				11 years
	resulting in death)	Due to (or as a conseq	uence of):				O
	Compartially list conditions						
Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				
Ē	Cause (Disease or injury that initiated events						
Xa	resulting in death) Last	Due to (or as a conseq	uence of):				
a							
dic							
Me	IF FEMALE:	On Marine automore of average					
an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		regnancy		23d. Date of de Month	livery Day Year
Sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐Unknown	leath 5 ☐ Other (sp	ecify)		WOTH	Day Tour
μŠ	9 □ Unknown	3EJOHINIOWII					
УΡ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying or	ause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
Be Completed by Physician/Medical Examiner	HUPRRTANS	IUN			1 ☐ Yes	2 No 3 □ P	robably 4 □Unknown
ete					24a. Was an	24h More o	utopsy findings available
힏					autopsy	prior to	completion of cause of
Ö					performed' 1 Yes 2 1	? death? No 1 ☐ Yes	s 2□No
e (	25. Was case referred to medical			26. Place of Dea	ath (Check only one)		
0	examiner? 1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	OA Other:	lome 5 🔀 Residence	6 □Other (Spe	ecify)
Ε.	27. Manner of Death	28a. Date of Injury		28c. Injury at Work?	28d. Describe how in		
io	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
cat	2 Accident investigation 3 Suicide 6 Could not be	OG - Disco of injury At h			005 1		Cum I Davida Alcumbau
Ħ	4 Homicide determined	28e. Place of injury - At he building, etc. (Special	fy)	/, onice	28f. Location (Street City or Town, St	and Number of H ate)	iurai noute ivumber,
Ce							
Medical Certification: To	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner a and place, and du	s stated. le to the cause(s)
Med	29h. Signature and title of certifier	and manner stated.	290	c. License number	294	Date signed (Mon	oth Day Year)
			1 -00		, 200.	orginou (MOI)	

DHMH 17 Rev 1/2001

State

Registrar

California

unit up

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John L. Bennett

DO019052

mD

		•	For State Registrar	State of Maryla		artment of H tificate of L		entai Hygie Reg		34139
±. 3€	Physicis	1. Decedent's Name (First, Middle, Last)  Physician Murtle Hollingsworth					2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	al	Myrtle Hollingsworth			4h City Tourn or			er 12, 2007 2301 <sup>M</sup>	
	Examin	Examiner  4a. Facility Name (If not institution, give street and number)  Gladys Spellman Nursing Center			4b. City, Town, or Location of Death  Cheverly			4c. County of Death Prince Georges		
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs	s. /ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	9 Date of Righ	o Ri	rthplace (State or Foreign
	Director		217-43-5202	☐ M 2[ <b>]</b> F	78 Yrs.	WOTHIS Days	riodis ivaii.	Month, Day, Y	1928 J	amaica
	and mand	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary		Md. PG		Uppe	er Marlk	oro			1 ∑Yes 2 ☐ No
	or 28s		10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	country?
	ath wi		17213 Clairfie			2077			Jnited S	
	Hems Inerra		11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No	U.S. 13.	Was Decedent of H I Yes, specify Cuba	ispanic Origin? (Spo In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
က္က က	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural" or itema 23a or 28a-f ahow marked other than "natural" or itema 23a or 28a-f ahow maric avant, ira Modeal Examinar must be multiliad at		3 ∑Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:			Specify:	Lack
2	72 ho		15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(Give	dent's Usual Occup	during most of work.	ing 16	b. Kind of Busines	
2	within		Elementary/Secondary (0-12)	Cottege (1-4or 5+)		DO NOT use retired			Deed -	
0 0	filed Hygie other		12 17. Father's Name (First, Middle, Last)		Nur	sing As		e (First, Middle, Ma	Priv iden Sumame)	ace
lan I	nid be Aental rked o	To Be	Altheous Will	iams			Mary 1	Edgar		
Maryland 21215-0036	2 a a a		19a. Informant's Name/Relationship (7	у́ре, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number, C	ity or Town, State,	Zip Code)
ک ک	1 and 1ealth 1m 27 ther tr		Carmen Prince/o	daughter	Uppe	r Marib	field La	20772	c. Location - City of	r Town State
وّ	ages nt of h t: if its		1 😡 Burial 2 □ Cremation 3 □							
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 2008:		4 ☐ Donation 5 ☐ Other (Specify 21. Signal e of Funeral Service Licen				ss of Facility Ho			lle, Md.
ñ	Dep de		Manice 8	durande						Md.20746
>			23a. Pay1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between							
39	Physician		Immediate Cause (Final disease or condition Sepsis							
a.	/Medical Examiner	er	Due to (or as a consequence of):							
			Sequentially list conditions, and any, leading to instruction of cause. Enter Underlying Cause (Disease or injury)  Renal Failure							
D.	ranslt	Examiner	resulting in death) Last  Due to (or as a consequence of):							
90	De exe cian a purial-i	by Physiclan/Medical								
68760,	tificate be executed g physician and as the burial-transit			d. MUICITOC	ai iac	nycarui	<u>a</u>		-t	
	_ U 0		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		75			23d. Date of d	lelivery
). Box	The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the		in the past 12 months? 1 Yes 2 XNo	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		JEctopic pregnancy Other (specify)			Month	Day Year
0	hat the		9 Unknown		esulting in the u	inderlying cause on	on in Part I	23e Did toba	cco use contribute	to the cause of death?
ds,	signe d be c		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobac Chronic Subdural Hematoma				2 No 3 Probably 4 Munknown			
co	w req	lete	Deep Vein Thro	ombosis				24a. Was an	24b. Were	autopsy findings available
æ	The law te has l	Be Completed	Deep verm mit	JIIIDOS I B				autopsy performe 1 ☐ Yes 22	d? death'	o comptetion of cause of ? es 2🔀 No
ij			25. Was case relerred to medical examiner?				26. Place of Deat	h (Check only one)		
<u>&gt;</u>	Physic this ce al dire	ို	1 ☐ Yes 2X No		☐ ER/Outpatie		421 Mursing Inc	ome 5 Residen		pecify)
n C	To the Hospital or Attending Physician: whin 24 hours after death. To the Funaral Director: After this certification the funaral Director. After the function completely filled in by the funeral director.	Certification:	27. Manner of Death  1 ⊠Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division of Vital Records,			3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At home, larm, street, factory, office		281. Location (Street and Number or Rural Route Number,				
á		Cert	4 Homicide determined	building, etc. (Spe				City or Town,	Srare)	
	ne Hospi n 24 hour ne Funar oletely fill	Medicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	withi To th	Ž	29b. Signature and title of certifier	muel		29c. Licens			Date signed (Mo	nth, Day, Year)
			> Lymerally				556	1	0/13/0	<u> </u>
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
8	Sta	ite	Humera Mujahid, M.D. 3001 Hospital Dr., Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 32. Megistrar's Signature							
	Regist	ar	OCT 2 4 2	007 January .	N A	ant.				

**Physician** /Medical Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760,

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Page Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by , page 2 s Be

certificate

To the Hospital or Attending Physician:

death.

Director:

within 24 hours a

Certification: To Medical

5 ☐ Pending investigation 1 💢 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ∏Yes 2 ∏No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D52261

29d. Date signed (Month, Day, Year) 10/4/07

20906

30. Name and address of person who completed cause of death (item 23a) (Type, Pint)

5117 HUGO ALLAN R SEGAL MD.

OCT 1 0 2007

32. Registral's Signature

CIRCLE SILVER SPRING MD

State

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 3, 2007 Esther Agatha Horning 9:52 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll 804 Francis Scott Key Highway Keymar 7, Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 24, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 3 F 82 Director 219-14-9698 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits fshow 'natural", or items 23a or 28a-f shov dical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Carroll Keymar Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21757 USA 804 Francis Scott Key Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: white δ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Bakery Assembly Line Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Julia Wantz William McClellan Vaughn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5791 Bowers Road, Taneytown, MD 21787 Lori L. Bowers, niece 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 KCremation 3 ☐ Removal from State 10/05/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signatury of Funeral Service Licensee 136 E. Baltimore Street, Taneytown, MD 21787 Jane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UNG /Medical Due to (or as a consequence of): OPD Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) detached the 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2 No Physician: To the Hospital or Attending Physician: within 24 hours af er death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 20054580 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. . D . WIL ST # D, TANEYTOWN MD21787 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WASIM FAKHAR, M.D. 417 E BALTIMORE 3 FAKHAR, 417 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elen & Sperk Registrar 2007

Dalminole, Maryland 21213	permit. Pages 1 and 2 should be filed within 72	important: if item 27 is marked other than "n: any lointy or other trainmate over the Madi	any milary or orner naminanc event, any mean
		rsici ledic amir	a Ci
DIVISION OF VIICE DECORDS, P.O. BOX 90700,	Ital or Attending Physician: The lew requires that the death certificate be executed	ns aren weam. San Director: After this certificate has been signed by the attending physician and lad in by the funaval director page 2 should be detached for use as the burial branch	the state of the second by the second of the

		1 - For State of Maryland / Department of Certificate of Certifica			2007 34142		
		Decedent's Name (First, Middle, Last)	1		3. Time of Death		
Phys /Me	ician dical	CLARA ANN HEIMS	Month Da ctober 9	9, 2007 10:30 A <sup>M</sup>			
	niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town	n, or Location of Death	40	c. County of Death		
			rmont ear   If Under 24 Hrs.   8	D-1(D:#	Frederick		
Funer Directo		225-50-6689 1 M 2 F 68 Yrs. Months Da	vs Hours Min.	Date of Birth (Month, Day, Year arch 17,	9. Birthplace (State or Foreign Country) Virginia		
land land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
Mary a-f shi ified a	j	Maryland Frederick Thurmont 1 Tyes 2□No					
th the or 28; e not	Funeral Director	10e. Street and Number 10f. Zip Cod	e	10g. C	itizen of What Country?		
ath w	20	109 Locust Drive 2	1788		U.S.A.		
ter de Items	in a	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 Married	of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.		
urs aff	2	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give	No Specify:		Specify: White		
72 hor naturalical E	peter	15. Decedent's Education 16a. Decedent's Usual Oc (Specify only highest grade completed) (Give kind of work do	cupation	16b. l	Kind of Business/Industry		
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ld be i ental ked o	To Be	Fred Corouge	Clara Arı		n ourname,		
shoul and M s mar umati			eet and Number or Rural F	Route Number, City	or Town, State, Zip Code)		
and 2 ealth a			Drive, Thurmo	ont, Mary	land 21788		
Tof He		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other)			Location - City or Town, State		
t. Pag tment tant:		4□Donation 5□Other (Specify) Resthaven Mem. (		<u> </u>	derick, Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	ouce,	General Marie 1015 EAST	MAIN SI., II	HURMUNT,	L HOMES, P.A. MD 21788		
		23a. Part1. Enter the disease, or complications below used the death. Do not enter the mode of shock, or heart failure. List only on the use of ach line.	dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between		
Physicia		Immediate Cause (Final disease or condition a Currisons of the lever			Onset and Death		
/Medica		resulting in death)  Due to (or as a consequence of):					
· · · · · · · · · · · · · · · · · · ·	Į,	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
cuted d	Fxaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events c.					
e exectan an an an arial-tr		resulting in death) Last Due to (or as a consequence of):					
icate be executed physician and the burial-transit	legical	d					
Sertification of ding page as	Med	IFFEMALE: 23c. If yes, outcome pf pregnancy					
leath certifi attending	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant 4 □ Pregnant at time of death 5 □ Other (specify			23d. Date of delivery  Month Day Year		
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lew ras be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
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ystcian: The vis certificate director, pag	a a	25. Was case referred to medical examiner?	26. Place of Death (C	A .			
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th. : Afte	itio	Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Injury at 28d Work? 1 ☐ Yes 2 ☐ No	a. Describe now in	ary occurred		
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tal or rs after ai Dir	Certification.	Building, etc. (opecity)		City or Town, Sta	,te)		
To the Hospital or Attending Physician: The lew requires that the death certification to the Fundament or Attending Physician: The lew requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Pedical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in rand manner stated.	e time, date and place, and ny opinion, death occurred	d due to the cause( f at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)		
To th withir To th comp	M	29b. Signature and title of certifier 29c. Lic	ense number	29d. D	Date signed (Month, Day, Year)		
3		Carner Dericand MD D3	35274		10/11/07		
0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  310 W 9th ST Frederick Md	2110)	·	1 /		
MA	State	31. Date filed (Month, Day, Year) 32 Registrar's Signature		<u> </u>			
Regi	istrar	OCT 1 1 2007 Some & Aprile		_			

Registrar DHMH 17 Rev 1/2001

State

By

GREGORIO M. BELLOSO, M. D.; 5302 CHINABERRY DR., SALISBURY, MD 21907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007 gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Month Vear **Physician** 200 /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1**X** M 2□ F 67 170-28-6667 1/29/1940 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Sussex Laurel Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10015 Loblolli Ave. 19956 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 construction carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Elizabeth Metzler Charles H. Hayes ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gail T. Hayes/wife 10015 Loblolli Ave., Laurel, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Eagle B.V. Co. 10/10/07 Leola, PA 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Holloway Funeral Home Professional Association Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netastatic **Physician** /Medical Due to (or as a consequence of): Examine Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FFMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death 1 Live birth Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 1 🗆 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Magner of Teath 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Cours!

OCT

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $A^{M}$ 2007 8:00 October 16, James Richard Istvan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf 14981 Truman Manor Lane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, June 14, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Country) Maryland 1 XM 2 ☐ F Yrs Ĩ935 214-32-9920 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2K No Waldorf Charles Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 USA 14981 Truman Manor Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Warehouse Worker Sunbeam Bread 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Istvan Mamie Buckler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14981 Truman Manor Lane, Waldorf, MD 20601 Cleo H. Istvan/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of October 19, St. Mary's Church Cem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Bryantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nam Bring rie ad Exchols Funeral Home, P.A. 21. Signature of Funeral Service L M00817 P.O. Box 128 Charlotte Hall, MD 20622 23a. Part1. Enter We disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ponknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 5 esidence 6 Other (Specify) Medicai Certification; To 28d. Describe how injury occurred 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 703 0 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State 8 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 18, 2007 4:55 PM M Sheldon Erwin Kishter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Heat1th Care Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Feb. 25 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F 1940 Washington, D.C 67 Feb. 578-52-6137 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at Union Bridge 1 Tes 2 INo Maryland Frederick Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21791 13211 New Windsor Road filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1059–1984 Year or Dates! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mes Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Robbin Tsrae1 Kishter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13211 New Windsor Road, Union Bridge, MD 21791 19a. Informant's Name/Relationship (Type. Print) Mrs. Gretchen Kishter, wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBuriat 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Oct. 31, 2007 Fort Myer, VA 4 □ Donation 5 □ Other (Specify) 21. Signat report Fundral Service Lice 22. Name and Address of Facility
Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) his Leteral Icleraris **Physician** CALS /Medical Examiner HONTHS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): physician a þe Physician/Medical attending p as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 as been signal b 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3 ☐ No has page certificate Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ဥ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 29a. Certifier 📬 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signator 29c. License number nd title of certifier 29d. Date signed (Month, Day, Year) October 19, 2007 00062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYECH IS CALLY, 4D 196 T.J. Drive, FLEOCNICK,

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

	1	For State Registrar	iaryiand / Depa <i>Cei</i>	rtificate of D		Reg.		31.11.
Physicia /Medic	ın	I. Decedent's Name (First, Middle, Last) BETSY	KIGHT		2	Date of Death Month 10	Py 2007	3.4 ime of beath 2047 M
Examine	er	la. Facility Name (If not institution, give street and number MEMORIAL HOSPITAL		4b. City, Town, or L	LAND	Data of Birth	4c. County of Death ALLEGANY	lace (State of Foreign
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	ge ( <i>In yrs. last birthday</i> ) 67 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye 4 / 2 2 / 4 0	ear) Cour	place (State or Foreigntry)
r-f show		10a. State 10b. County WV Mineral	10c. City, Town or Lo	ocation			1	10d. Inside City Limit
3a or 28a st be noti	ā	10e. Street and Number 86 Gilmore Street	•	10f. Zip Code 2 6	726	10g.	U.S.A.	ntry?
	ᆵ	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  1 □ Vas Deceder Armed Force:  1 □ Yes 2 Married  1 □ Yes 2 We Year or Dates	I No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 № No	panic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Wh	
than "natur the Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  L 2  College (1-40)	(Give	edent's Usual Occupa e kind of work done du DO NOT use retired) Teller	tion uring most of working		b. Kind of Business/In	•
and Mentai Hygi is marked other aumatic event, tl	To Be C	17. Father's Name (First, Middle, Last) Herbert W. Anderson			18. Mother's Name (		<sub>iden Surname)</sub> ch Frazer	
Health and M em 27 is mar ther traumat	_	19a. Informant's Name/Relationship (Type. Print) Norman Kight/husband					ity or Town, State, Zij WV 2672	
nent of Heg ant: If Item ury or othe		20a. Method of Disposition 1 ◯XBurial 2 □Cremation 3 □Removal from Sta 4 □Donation 5 □ Other ( <i>Specify</i> )	20b. Place of Dispresentery, cree	osition (Name of ematory or other place C Memoria	Da al 10/2	i i	c. Location - City or T Keyser,	
Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	adler	P.O. Bor	d Funera x 912. K	evser	WV 26726	
y physician and physician and physician and physician and street transit are the principle.	edical Examiner	Due to (or Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of): as a consequence of): as a consequence of):	r M-	elli fu	i sea	5-8	Days
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within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be	njury 28b. Time Injury injury - At home, farm, s	M 1□	Yes 2 □ No	3d. Describe how Bf. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
24 hours a  E Funeral I  etely filled	Medical Ce	29a. Certifier (Check only one)  2 Medical Examiner: On the basi and manne	s of examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
within To the	Me	29b. Signature and title of certifier	MD	29c. License			d. Date signed (Month	
5		30. Name and address of person who completed cause	- Reserva	e, Print)	Soo M	nemis ber l	ctober	10512 462M-
Sta Regist		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	metal				

			For State	State of I	Maryland / D	epartment o Certificate					34148
			Registrar  1. Decedent's Name (First, Middle, La	st)		Jeilineale	UI Dealii	2. Date of	Reg. No.	.001	3. Time of Death
	Physici	an		*****				Month	ber 19		
	/Medic		Boyd Junior  4a. Facility Name (If not institution, give			4b. City. To	wn, or Location			County of Death	2:20 a. <sup>™</sup>
	Examin	er						or Dount	10.		
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п	Director		234-64-3290	<b>X</b> M 2□F	64 Y	rs. Months D	ays Hours		Day, Year) 7,194		ck Oak, MD
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	rylan how		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
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Maryland	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Martical Examinating the notified at ODGs.	2	19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (S		zel M. Kim er or Rural Route Nu		r Town, State, Z	ip Code)
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altimore,	artme ortan injury	- 1	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Lices</li> </ul>		Dawson	Cemetery 22. Name and		2007 Ty Smith Fo		wson, M	D
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each	h line.	Λ	. 1		,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Sall La	m //	ilulp				2- lux
п	Examiner			Due to (or	as a consequence of	):					
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	hour hour uner uner		29a. Certifier 15 Certifying Ph	ysician: To the be	est of my knowledge, s of examination and	death occurred at i	he time, date ar	nd place, and due to	the cause(s)	and manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	ledical	one)	and manner	stated.			AUT OCCULIED AL LINE (II			
	With To 1	Σ	29b. Signature and title of certifier			29c. L	cense number			e signed (Month	
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	5		30. Name and address of person who	completed cause of	of death (Item 23a) (T						
	J		Rabie Zalzal, M	.D. 53	7 S. Miner	al Stree	t K	eyser, WV	267	26	
	Sta		31. Date filed (Month, Day, Year)	07 37. Reg	istrar's Signarure	posts.					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gerard Francis Kiernan Oct. 6, 2007 9:45 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Gardens Nursing Center Lanham Prince George's 8. Date of Birth (Month, Day, Year) March 13, 1946 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min New York 215-54-8780 61 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at Director Maryland| Prince George's Riverdale Park 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5309 Riverdale Road 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2K No Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Space Flight Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth other traumatic even Be Eileen Helen O' Malley Francis Joseph Kiernan P 19a. Informant's Name/Relationship (Type. Print) Friend & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5230 Loughboro Road NW, Washington, DC Andrew H. Diem-Personal Rep. permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 10/14/07 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 M01491 14Chelle 24a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final **Physician** Carcinoma of the Stomach months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760 attending physician the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should i 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No performed' 1□ Yes 2 No Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 🗀 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 1 X Natural 5 Pending Iniun 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 s. In 24 hour. the Funeral Dire. 4 Homicide 29a. Certifier Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 1 (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25079 10/8/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Don H. Yablonowitz, M.D. 7404 Executive Place #502, Greenbelt, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 2007

			For State Registrar	State of N	Naryland / De <i>C</i>	partment of F ertificate of		-	giene Reg. No. <mark>2      </mark>	7 34150	
	Physic		Decedent's Name (First, Middle Harold Irvin					2. Date of De	ath	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution 307 Wampler Co		r)		r Location of Death minster		4c. County of Death  Carroll		
	Funeral Director		5. Social Security Number 217–40–4037	6. Sex 7. / 1 M 2 F	Age (In yrs. last birthd 64 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Dec 1	6 1942	9. Birthplace (State or Foreign Country) PA	
	nyland how	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or					10d. Inside City Limits	
	with the Ma a or 28a-f s be notifled	Funeral Director	MD Car: 10e. Street and Number 307 Wampler Cor	roll	West	ninster 10f. Zip Code 211	58		10g. Citizen of Wh	1 □Yes 2 🛣No at Country?	
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		11. Marital Status  1 Never Married 2 Marital Marital Status	12. Was Deceder Armed Forces 1 X Yes 2 1 1 Yes Give	1961	3. Was Decedent of H If Yes, specify Cub		pecify Yes or No Decify Yes or No Decify Yes	- 14. Race -	American Indian, White, etc. White	
21215-0036	within 72 ho iene. • than "natu the Medical	Completed by	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4o	(G lif	cedent's Usual Occup ive kind of work done e. DO NOT use retired rchasing A	during most of world)	king	16b. Kind of Busi Univers Baltimo	ity of	
	be filed tal Hygi d other event, th	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surname)	)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	្ន	John D. Bookar 19a. Informant's Name/Relations	ship (Type. Print)		ailing Address (Street	and Number or Ru		er, City or Town, Si		
	Health tem 27 other tr	L	Dorothy Keith/W. 20a. Method of Disposition	ife		07 Wampler sposition (Name of the of			ster, MD	21158 ity or Town, State	
Baltimore,	Pages ment of h ant; If Ite lury or of		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		<sup>®</sup>   Carroll	Cremation	_Inc	9/2007	Hampste		
Balt	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau		21. Signature of Funeral Service	Lidensee		Přitts Fun 412 Washin			_		
	Physician /Medical Examiner		23a. Part1. Ent. the 1 sease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aa	ed the death. Do not line.  as a consequence of):	enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death  MONTH	
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	is a consequence of):						
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	/		23d. Date Monti		
	equires that en signed b ould be deta	b	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause giv	en in Part I.			ute to th ause of death?	
or Vital Records,		Completed						1□ Yes	2 No 1	ere autopsy findings available or to completion of cause of ath? Yes 2 \( \square\) No	
r Vit	Physician: r this certificanal director, I	To Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpa	tient 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H		ve) dence 6 □Other	(Specify)	
o uo	ding Pl h. After t	tion:	27. Manner of Death  1 ☐ Natural 5 ☐ Pendin  ☐ Accident investignment	28a. Date of Ir (Month, D gation	njury 28b. Tim Day Year) Injui	y Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occurred	j	
Division	To the Hospital or Attending within 24 hours a 'er dea'h. To the Funeral Director After completely filled in by the funer	Certification:	3 Suicide 6 Could determ	singer   Zoe. Flace of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tox		or Rural Route Number,	
	e Hospita 124 hours e Funera	Medical C	29a. Certifier 1. Certifying (Check only one)	g Physician: To the best Examiner: On the basis and manner	of examination and/o	eath occurred at the ti r investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mani date and place, an	ner as stated. nd due to the cause(s)	
	To th	Me	29b. Signature and title of contine			20 Licens		7	29d. Date signed (	(Month, Day, Year)	
_	STIN		30. Name and address of erson	555.Sa	th Caute	y Strut	WSTM.	wster	m) 2115	57	
	Sta Regist		31 Date filed (Month, DayLYear) OCT 0 9	2007 32 regis	strar's Signature	bark					
DLI	MU 17 Day 1/0	004									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 6 2007 9:00 ам Margaret Virginia King 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Carrol1 Manchester 3262 York Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Days Min. Mar 13 1943 Months Hours 1 M 2 T F MD 64 220-40-1591 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Manchester Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21102 3262 York Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Balancer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Fahey Phillip Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3262 York Street Manchester, MD 21102 Noble King/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/11/2007 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Hampstead, MD Carroll Cremation, Inc 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses The artifles of a thome and Chapel, P.A. 412 Washington Rd Westminster, MD 21157 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) luna cance Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 7 No 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes 26. Place of Death (Check only one)

Physician /Medical **Examiner** The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me

Maryland 21215-0036

Baltimore,

Box 68760.

P.O. I

or Vital Records,

Division

Hospital or Attending Physician:

To the

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within 72

Director

Funeral

þ

Completed

Examine

attending physician and for use as the burial-transit Physician/Medical been signed by the s ģ Completed page 2 s ours after death.

neral Director: After this certific filled in by the funeral director, Be ဥ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

29a. Certifier

Medical

State

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other:

28d. Describe how injury occurred

3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier rolino

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. Brahmer, MD 31. Date filed (Month, Day, Year) OCT 0 9 2007

Street, Registrar's Signature

1650 Orlean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:00 **Physician** October 9, 2007 Elizabeth Mary Kelly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2¥ F 82 Yrs. Director 217-28-8543 February 10,1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1 Yes 2 No Directo St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20650 22680 Cedar Lane Court, Apt. 1132 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1□ Yes X No Maryland 21215-0036 Specify Specify: 3 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home ages 1 and 2 should be filed vent of Health and Mental Hygie to If Item 27 is marked other ty or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph S. Herbert Mary Magdaline Scriber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Scott / Daughter 22845 Town Creek Drive, Lexington Park, Maryland 20653 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H October 0 1 Burial 2 □ Cremation 3 □ Removal from State Important: I any Injury o 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Cemetery 16, 2007 Great Mills, Maryland 21. Sign Pure of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. And Mey P.O. Box 270, Leonardtown, Maryland 20650 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Anthenoscienotic Immediat Cause (Final Ennoivensalan Nicesa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has autopsy performed death? certificate 2 ... No 1∐ Yes 2 - No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Box 68760. P.O. Division or Vital Records,

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

David M. Federle, M.D.

OCT 15

DHMH 17 Rev 1/2001

Fulue MA

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24035 Three Notch Road, Hollywood, Maryland 20636

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D34157

29d. Date signed (Month, Day, Year)

F	hysicia		State of Maryland / Department of Health and Maryland / Department / Department of Health and Maryland / Department / Depart	vicinai i iygi	9	34153
Fı	/Medic Examin uneral rector	er	4a. Facility Name (If not institution, give street and number)  Venus Jo Region Medica Center  5. Social Security Number  1. Age (In yrs. last birthday)  1. Age (In yrs. last birthday)  1. Months  1. Age (In yrs. last birthday)	8. Date of Birth	4c. County of Dear Wick M	
e Maryland	a-f show tified at	ctor	10a. State 10b. County MARYLAND WICOMICO 10c. City, Town or Location SHARPTOWN			10d. Inside City Limits 1 X Yes 2 No
th with th	23a or 28 ıst be no	Funeral Director	10e. Street and Number 200 LITTLE WATER STREET 10f. Zip Code 21806	10	og. Citizen of What Co AMERICA	ountry?
5-00.50 72 hours after death with the Maryland	If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Woldowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:		14. Race - Ame Black, Whit Specify: WH	e, etc.
d c l c l 3-0 filed within 72 ho Hygiene.	r than "natul the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12YRS •  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  SOCIAL WORKER	king	STATE OF	
yland A	rked other tic event,	To Be C		e (First, Middle, N ELLIOT		
and 2 should salth and Men	27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print)  JOHN D. ELLIOTT - COUSIN  19b. Mailing Address (Street and Number or Ru 216 N.SHORE CT.SEA			
Dartinol C.	Important: If item any injury or othe once,		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Der (Specify)  20b. Place of Disposition (Name of MARTELA MEMORTAL 10/1  CEMETERY  21. Signature of Inera/Service Licensee/	1/07	ARDELA <sup>II</sup> S MARYLAN HOME, IN	D
/Mo Exa	sician edical miner miner	al Examiner	23a ant Enter the disease, o complications that coased the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. Lift only one cause on each line.  Immediate Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Interval Between Onset and Death
The law requires that the death certificate by	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medica	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of de Month	livery Day Year
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aw re	has bee je 2 sho	Completed		24a. Was ar autops perforn	y prior to	utopsy findings available completion of cause of
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ng Physician:	:tor: After this certificate has the funeral director, page 2	To Be	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing H  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be  28a. Date of Injury 28b. Time of Injury Work? 1 Yes 2 No  28b. Time of Injury M  1 Yes 2 No	ome 5 Reside	nce 6 Other (Spe w injury occurred	
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ng Physician:	To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical Certification: To Be	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing H  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury M  (Month, Day Year)  28b. Time of Injury M  Nursing H  28c. Injury at Work? 1 Yes 2 No  28e. Place of injury - At home, farm, street, factory, office	th (Check only one ome 5  Reside 28d. Describe ho 28f. Location (Str. City or Town a, and due to the caurred at the time, d	nce 6 Other (Spewin injury occurred  reet and Number or R, State)  ause(s) and manner a ate and place, and du  add. Date signed (Mon	ural Route Number, s stated. e to the cause(s)

0, State

31. Date filed (Morning Pey, Year 9 2007

Registrar DHMH 17 Rev 1/2001 32 Legistrar's Signature

State of Maryland / Department of Health and Mental Hygien 2007

34154

		C	ertificate of	Death	Re	g. No.	
	Decedent's Name (First, Middle, Last)				2. Dete of Deeth Month	Day Year	3. Time of Death
Physician /Medical	BARBARA	KLUSSAY			OCT. 1	_	10:20 PM
Examiner	4a Fecility Neme (If not institution, give street and nur		4	b. City, Town, or Lo	cation of Death	4c. County of Deet	
	SACRED HEART HOME			HYATTSV	ILLE	PRINCE (	GEORGES
Funeral		7. Age (In yrs. last birthda	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
Director	094-64-1014 1□ M 21XF	88 Yrs.	· Indiana Baya	Tiodio Mini	MARCH 11	,1919 SLC	OVÁKIA
D .	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City, Town or	Location				10d. Inside City Limits
ehow							1 ☑ Yes 2 □ No
Ba-f	MD. PRINCE GEORGES		HYATTSVILL	E			24
th with the Maryle 23s or 28s-f sho ust be notified at	10e. Street end Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
United to the Main the Main the Main the Main the Main the main the notified the real Director	5805 QUEENS CHAPEL R			782		U.S.A.	des le diss
tar de lar de lar de la la	Armed Fo	edent Ever in U,S. 1:	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
urs aff	1 Never Married 2 Married 1 Yes If Yes, Giv 3 Widowed 4 Divorced Year or Do	'e	1 ☐ Yes 2 💢 No	Specify:		Specify:	HITE
and 21215-0020  be filed within 72 hours after death with the Marylend tal Hygiene. d other than "natural", or items 23a or 28s-f show event, the Medical Examinat must be notified at  Be Completed by Funeral Director	15. Decedent's Education	16a De	cedent's Usual Occup	ation	1	6b. Kind of Business/	
thin 7	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1	-4or 5+)	ive kind of work done on DO NOT use retired	during most or workii 1)	ng		
N DEF	12		SECRETAR	Y		SECRETAR	[AL
be filed tal Hygie d other event, the Co	17. Fether's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Surname)	
arylar should by ind Menta inmerked urmette ey	GEZA KLUS	SAY			ANNA	KISS	
Maryland 42 should be file h and Mental Hy ls marked othe traumatic event,	19a. Informant's Neme/Reletionship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Rure	l Route Number,	City or Town, State, 2	Zip Code)
_ 2 = N	CAMILLA J. KARI/NIECE		E. MAIN S	T., SCHUY			
ges 1 t of H or off	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from 5	nomotons a	sposition (Name of trematory or other place	e)	Date 2	0c. Location - City or	Town, State
Pages nent of ant: If Its ury or o	4 □ Donation 5 □ Other (Specify)	СНАМВЕ	RS CREMATO	RY 10	0-18-200	7 RIVERDA	ALE, MD.
Baltimore, permit. Pages 1 er Depertment of Hea Important: If Nem 2 any Injury or other DRGs.	21. Signature of Funeral Service Licensee	100	22. Name and Addres	UNERAL HO	ME & CRE	MATORIUM,	P.A.
	23a Part 1 Enter the disease or complications that co	1100071	5801 CLEVE				Approximate
Dhysisian	23a. Part1. Enter the diseese, or complications that conshock, or heert failure. List only one cause on experience of the constant of the cons	ach line.	sine the mode of dyin	g, such as cardiac c	r respiratory arres	51,	Interval Between Onset and Death
Physician // // // // // // // // // // // // //	Immediate Cause (Final						
Examiner	disease or condition resulting in death)  A YOC	ARDIAL INFAI					
<u> </u>		Due to (or as a cons				I	
axecuted in and ital-transit	U	RIOSCLEROTION  Due to (or as e cons		SCULAR DI	SEASE		
Dy, axec in an ial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury					1	
ificate ba a physician as the bunicate	trial trittated events	Due to (or as e cons	**				
	resulting in death) Last	240 to (01 440 0 00110	0400100 01).				
ath certi	d						
at the death or dby the ettend atached for us	Part II. Other significant conditions contributing to de	ath but not resulting in the	underfying cause give	en in Part I	23h Did tob	acco use contribute	to the cause of death?
trha by the latcher			andonying sauce give	or area.			robably 4K Unknown
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ords, requires t een signe nould be	•				24a. Wes an		Were autopsy findings available prior to
law relay be as be as be and a short and a					perform		completion of cause of death?
The law requir sata has been s pega 2 should					1 U Yes		1 ☐ Yes 2 ☐ No
Star: Tanger of the color. Pe C. Be C.	25. Was case referred to medical			26. Place of Death			
hysicle hysicle lidirect	examiner?	npatient 2 ER/Outpati	ient 3□ DOA Othe		-	nce 6 Other (Spe	cifu)
Participant T. T.		f Injury 28b. Time	of 28c. Injury		8d. Describe hov		ony)
ation	1 Maturel 5 Pending (Monti 2 Accident investigation	h, Day Year) Injury		(? Yes 2 □ No			
Atter dea perior de by the by the	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place	of Injury - At home, farm,	street, factory, office	2		eet and Number or Ru	ural Route Number,
be or Attending P is after death.  In Director: After to the in by the funer control of the f	4 Li Horricide buildin	g, etc. (Specify)			City or Town,	State)	
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours faster death.  To the Funerel Directors attending centificate has been signed by the ettendin completaly filled in by the funerel director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N	29a. Certifier (Check only one)  Certifying Physician: To the ba	sis of examination and/or	ath occurred at the tim investigation, in my or	ne, date end place, a pinion, death occurre	and due to the cau ad et the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
ithin 2 the of t	29b. Signeture and title of certifier	ai steteu.	29c. License	number	29	d. Date signed (Mont	h, Day, Yeer)
F3F8	* Kallings	ton.	119	609			
	20 Normal Marie Ma	of doods fire San S	- Point)	50		oct 16	10001
	30. Name end address of person who completed cause RAMAN R. TULI, M.D.		e, Print) ARNESTOWN 1	מא מא	ard Criido	MD 200	79
State		gistrar's Signature	MINEDIOWN I	w., GAIII	- DAUGGALL	, FID. 2007	· O
Registrar		er to fight					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 8876 2-11-08 vt. State of Maryland / Department of Health and Mental Hygiene 341 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Physician BOLT М ELIZABETH LEWIS 10 17 2007 1915 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. At Date of 25h yel 927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 24 □ F 80 215-20-7076 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County MD Allegany 1 ☐ Yes 2 🕱 No Corriganville Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be be ms 23a USA 13208 Ellerslie Road 21524 14 Race - American Indian "natural", or items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personnel Director Retail marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Int. If Item 27 is marked of Theresa (Ward) Brannon James Brannon r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Charles Lewis Spouse 13208 Ellerslie Road, Corriganville, MD Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State Memorial Park Oct. 22 07 Cumberland, MD 22 Name and Address of Facility Hafer Funeral Service, PA 4 Donation 5 ☐ Other (Specify) Sunset 1302 National Hwy., LaVale, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** month Adenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 28a. Date of Injury 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director; / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direc

completely filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5

State Registrar Name and address of person who completed cal

ivengood

Drive, Cumberland Maryland 21502

use of death (Item 23a) (Type, Print)

MD

32, Registrar's Signature

912 Seton

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** Arnicia Logan october 2007 12:12 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner George's Southern CliMUN Mary land Hospital Prince If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, June 18 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1959 Months 1 □ M 2 □ F Mississippi 577-80-3457 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 77 is marked other than "natural", or flems 23a or 28a-f shov traumatic event, the Medical Examiner musts be notified at traumate event, the Medical Examiner musts be notified at 1 X Yes 2 No Director MD Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7859 Riverdale Rd # 203 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 ▼ No Specify. Specify: λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Nurse 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morine Armstrong E. J. Logan ပ 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Maemoore Court District Hgts. Maryland 20747 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is r Logan/Son Larry 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-12-2007 Riverdale, Maryland Riverdale Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications Gastro intestinal Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician use as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tyes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2□No 24a. Was an certificate 2 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Medical Certification: To 1 🗍 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vesTe SMIVADOR 201 32. Registrar's Signature State Registrar

baltimore, maryland 21213-00	permit. Pages 1 and 2 should be filed within 72 hou	Important: if item 27 is marked other then "nature	any injury or other traumatic event, the Mudical E
	Phy /N Exa		cia lica ine
on or vital Records, P.O. Box 68/60,	iding Physician: The law requires that the death certificate be executed	<ul> <li>After this certificate has been signed by the attending physician and</li> </ul>	funeral director, page 2 should be detached for use as the burial-transit

	1 - For State Registrar  1. Decedent's Name (First, Middle		Maryland	/ Departm Certific			Mental Hy	Reg. NZ UU /	3415
nysician Medical xaminer	James  4a. Facility Name (If not institution	Johnny	Lemon	4b. C	ity, Town, or	Location of De	Octob	er 3, 2007	11:13 A.
neral ector	Washington Ad 5. Social Security Number 250-70-7883		spital Age (In yrs. Ias 65	t birthday) If Ur Yrs. Mont	der 1 Year	a Park If Under 24 H Hours Mi	n. 8. Date of Bi	Montgo irth ay, Year) 1941 er 8, So	mery Birthplace (State or For Country) uth Carolin
tor 28a-f show be collised at Director		ce Georges		Town or Location				10-07(111	10d. Inside City Li
ō # 🗖	10e. Street and Number  4406 - 29th  11. Marital Status	12. Was Dece	dent Ever in U.S.		Zip Code 2071 accedent of Hi		(Specify Yes or Nerto Rican, etc.)	United S	tates merican Indian,
LEvanina d by Fur	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Da	2 X No tes:	1 □ Ye	s 2 <b>X</b> No	Specify:	erto Rican, etc.)	Specify: ]	
t, the Mudical I	15. Deceder (Specify only higher Elementary/Secondary (0-12)  5th grade	nt's Education est grade completed)  College (1-		16a. Decedent's I (Give kind o life. DO NO Sanitat	work done o Tuse retired	during most of v 1)	vorking	City of C South Ca	harleston,
atic event, To Be C	17. Father's Name (First, Middle, Preston Jaco	bs Lemon				Este	lle Fra		
important: it tiem 27 is marked other then hatural, or tams 238 any injury or other traumatic event, the Mudical Examinar must once.  To Be Completed by Funeral	19a. Informant's Name/Relations  Jeanette Laver  20a. Method of Disposition  1	The William  3 □Removaf from S  Specify)	S 20b. Plac	4406 – 2 ce of Disposition netery, crematory sapeake	29th S Name of or other place Cremat	treet;  Oct ory, In	Mount Ra .10,2007	Beltsvill	land 20712 or Town, State e, Marylan
an and transit ransit ransit Examiner		a. Mult Due to (c  b. Meta Due to (c	i <b>ple Mye</b> oras a conseque	Do not enter the eloma noe of):  Bone Cane	Kenned mode of dyin	y Stree	t, N. W.	icians, In ; Washingt arrest,	Approximate interval Betwee Onset and Dea
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bi	ome of pregnance.  th 2 Fetal digital from the attime of dealers.	eath 3 □Ectop	ic pregnancy r (specify)	/		23d. Date of Month	delivery Day Yea
2 should be d	Part II. Differ significant conditi	ions contributing to de	ath but not resulti	ing in the underlyi	ng cause giv	en in Part I.	24a. Wa	I tobacco use contribut  Yes 2 No 3   Is an opsy formed? 2X No 1 1	Probably 4 X Unk
uner this certification in the sector.	25. Was case referred to medical examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Ir  28a. Date o  (Month itigation		R/Outpatient 3[ 8b. Time of Injury	DOA Oth  28c. fnjur Wor	er: 4 🗆 Nursin		y one) sidence 6 □Other (as how injury occurred	Specify)
To the Funeral Director: Attert completely filled in by the funeral Medical Certification:		mined 288. Place	g, etc. (Specify)	e, farm, street, fa	,	me, date and ol	City or T	(Street and Number of own, State)	
mpletely fille	(Check only 2 Medica	I Examiner: On the ba	sis of examinatio er stated.	on and/or investiga	ation, in my o	pinion, death of	ccurred at the time	e, date and place, and	due to the cause(s)

DHMH 17 Rev 1/2001

State Registrar

completely

(Check only one)

29b. Signature and title of certifier

29449 ESPHANIMD CHARLOTTE HALL RD, CHARLOTTE HALL 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

07-07826 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert Lookingbill, Sr. 2007 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 7, 2007 1018 hrs **Medical Examiner** Robert L.Lookingbill 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Taneytown Carroll 465 E. Baltimore Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or April 123, Foreign Country) MD 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director April 220-40-9991 64 1 / M Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 /No or 28a-f show Taneytown Carroll Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If it it may 73 marked other than "natural", or items 23a or 28a-f sho
injury or other tranumitie event, the Medical Examiner must be notified at once. MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21787 USA 5041 Harney Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 / Married Yes White Yes, Give Year Yes 2 No specify: Specify. Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Manf.Air Conditioner Built air Conditioner 8 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E.King Thomas R.Lookingbill 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State-Zip Code) Margaret W.Lookingbill-Wif 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/12/07 Harney, MD Cemetery .View Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 34 Maple Ave.Littlestown, PA Little's FH 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) ned by the atte Yes 2 No 9 Unknown Unknown of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 Yes 2 1 the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other; Residence 6 Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient After this မ 1 ✔ Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending 24 hours after death. Funeral Director: filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 8, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali M.D. 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registra

OCI

ORIGINAL

32.

OCME

Certificate of Death

Reg. No. 2007

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

2. Date of Death OCTOBER

SHIRLEY AVALON QUOTON LEWIS

2007

9:15 A M

10d. Inside City Limits

**Funeral** 

Director r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director death Funeral e filed within 72 hours after al Hygiene. I other than "natural", or Ite ð Completed Be h and Mental I 1 and 2 should be

permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and and Important; If Item 27 is any injury or other trauonce.

burial-transit

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page 2 s

director

funeral

n 24 hours after death.

Pe Funeral Director: A

Interest filled in by the fi

To the Hos within 24 ho To the Fun completely 1

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Be Completed

Certification: To

Medical

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Maryland 21215-0036

altimore,

4a. Facility Name (If not institution, give street and number) RESIDENCE. 4395 LIVINGSTON ROAD

4b. City, Town, or Location of Death INDIAN HEAD

4c. County of Death CHARLES

216-22-3555 Usual Residence of Decedent

10b. County

1 □ M 2 F

10c. City, Town or Location

7. Age (In yrs. last birthday)

81

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreit (Month, Day, Year) | FFBRUARY 15, 1926 | WASHINGTON, D.C.

9. Birthplace (State or Foreign

MARYLAND

CHARLES

INDIAN HEAD

1 ☐ Yes 2 No

10e. Street and Number

5. Social Security Number

4395 LIVINGSTON ROAD

10f. Zip Code 20640

10g. Citizen of What Country? UNITED STATES

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🗓 No Specify:

14 Bace - American Indian Black, White, etc. Specify: **BLACK** 

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

TEACHER

EDUCATION

HENRY QUOTON

18. Mother's Name (First, Middle, Maiden Surname) ESTHER LILLIAN (DATCHER) QUOTON

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, MARY LAND) 20640 4395 LIVINGSTON ROAD / P.O. BOX 1137 INDIAN HEAD.

ROBBIE N. LEWIS, JR. / SON 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

M00583

ARLINGTON NATIONAL CEMETERY OCT. 31,2007 ARLINGTON, VIRGINIA 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Date

21. 515 Aug of Fundral Service Licensee Library Of Fundral Service Licensee

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

10 YEARS

immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine

_a	PARKINSON'S DISEASE
	Due to (or as a consequence of):
b	Due to (or as a consequence of):
C	
	Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□Unknown

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

1□ Yes 2X No

28d. Describe how injury occurred

27. Manner of Death 1 A Natural 2 Accident

5 Pending investigation 6 Could not be 3 Suicide determined 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

30. Name and addr

1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

29b. Signature and title of certifier

0101230240 VA

OCTOBER 5, 2007

ANDREWS AIR FORCE BASE, CAMP SPRINGS, MD

State Registrar

31. Date filed (Month, Day, Year)

Sperke

PLUMLEY, MD 1075 WEST PERIMETER) ROAD, OCT 1 0 2**0**07

of person who completed cause of death (Item 23a) (Type

		4	For State Registrar	State o	of Maryland		rtment of Hotificate of D			iene 0 0	7 34161	+
	Physicia	an	Decedent's Name (First, Middle, Wayne		ayfield				2. Date of Deat Month October	Day	3. Time of Death 7 5:03 PM	VI
	/Medic Examin		4a. Fecility Name (If not institution, g	ER	4b. City, Town, or Location of Death SALISBURY			4c. County				
	Funeral			. Sex 1 M M 2 □ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. (Month, Day,	Year)	Birthplace (State or Foreig Country)	n
-	Director		Usual Residence of Decedent		65				4/1/194	2	Maryland	
	oeain with the maryland me 23a or 28a-f ehow Imust be notified at	_	10a. State 10b. County	•		, Town or Lo	cation				10d. Inside City Limit 1 ☐ Yes 2 XN	
1	28a-f	Directo	Maryland Wicom  10e. Street and Number	100	DE	elmar	10f. Zip Code		1	Oa. Citizen of \	What Country?	
	Sa or 3	וַם	31810 Melson R	oad			21875	5		USA	,	
	deam	Funeral	11. Marital Status		cedent Ever in U.	S. 13.	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ce - American Indian, ck, White, etc.	
20	d within 72 hours after dearn with the manylangiene. Jene. Than "natural", or iteme 23a or 28a-1 ehow to Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced		2 <b>∑</b> No ive		1 ☐ Yes 2 🙀 No	Specify:		Specif	y: white	
3-003p	atural cal Ex		15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ition		16b. Kind of B	usiness/Industry	
7	Ithin /	Completed	(Specify only highest Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	DO NOT use retired,	)	, many			
7 7	\$ <del>\$ 6</del> <del>6</del>		12 17. Father's Name (First, Middle, La	ast)		farme	er	18. Mother's Na	me (First, Middle,		ulture	
and	o a a a	To Be	Paul L. Layfiel					Viola	Nellie Au	ustin		
Mary	s 1 and 2 should be 1 f Health and Mental b fem 27 is marked of other traumatic eve		19a. Informant's Name/Relationshi Betty Mae Layfi				ng Address (Street a				, State, Zip Code)	
ē,	ss 1 and 2 of Health a item 27 is other train		20a. Method of Disposition 1   Burial 2 □ Cremation 3		٥ ا ٥	emetery, crei	sition (Name of matory or other place	e)	Date	20c. Location	- City or Town, State	
	Pages ment of tant: if it jury or o		4 □ Donation 5 □ Other (Spe	ecity)	Spr	ingni irdens	LI Memory	10/	10/07	Hebro		
gail	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service		SP	22 I	Holloway 1 501 Snow 1	funeral Hill Rd.	Home Pro: , Salisb	fession ury, MC	nal Association 21804	1
	a),		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that nly one cause on	caused the death each line.	h. Do not ent			ac or respiratory arr	rest,	Approximate Interval Between Onset and Death	
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	fute (	own	any Jyh	drave				
1.4	Examiner			Due to	or as a conseq	uence of):	50					
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dua to	peence e ea to) o	uenes di):						
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due te	o (or as a conseq	uence of);						
8760	death certificate be executed e attending physician and od for use as the burial-transit	dical E	•	d								
99	artifical ing phy e as th	Medi	IF FEMALE:						8311			
Box	teath certifica attending ph I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 ☐ Feta mant at time of d	Ideath 3	☐Ectopic pregnancy ☐ Other (specify)				ate of delivery onth Day Year	
o.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	nown							_
S,	The law requires that the de ate has been signed by the a bage 2 should be detached t	ρ	Part II. Other significant condition	s contributing to	death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	1-	ntribute to the cause of death?  3 Probably 4 Unknown	
örö	w require been si should b	eted	14.40 4.00		VIVA	<i>x</i> c) <i>v</i>	-41,1-5		24a. Was		. Were autopsy findings availal	ble
Records,	he tav e has age 2 :	Completed	17 gpentunit						autop perfor 1 🗆 Yes	sv	prior to completion of cause of death? 1 ☐ Yes 2 No	)l
ta	ilcian: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of De	eath (Check only o	7		
<u>&gt;</u>	Physic this ce al direc	To B	examiner? 1 □ Yes 2 No			ER/Outpatie		4   Italiania	Home 5 Resid			
UC C	Attending Physician: or death. ector: After this certification in the funeral director.	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig		e of Injury onth, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	low injury occu	arred	
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	Certification:	2 Accident investig: 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Pla	ce of Injury - At h Iding, etc. (Specia	ome, farm, st fy)	reet, factory, office		28f. Location (S City or Tow	Street and Num vn, State)	ber or Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Directional Completely filled in I		29a. Certifier Certifying	Physician: To t	he best of my kno	owledge, dea	th occurred at the tir	ne, date and place	ce, and due to the	cause(s) and n	nanner as stated.	
	To the Hospita within 24 hours To the Funeral completely filled	ledical	one)		basis of examina anner stated.	ation and/or if					e, and due to the cause(s)  med (Month, Dey, Year)	
	To To the	Σ	29b. Signature and title of certifier	01			29c. Licens	9 number		290. Date sign	2 h	
-	loni		30. Name and address of person v	who completed ca	use of death (Item	m 23a) (Type		121		(3)	101	
	Dro		J.C. Patracioz.		205 wee	of Bos	Dir S	-te (01	Solish	mD	21804	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	07	Registrar's Sign	ature	K)		·			

		State of Maryland / Department of Health and	Mental Hygiene
		1 - State State Certificate of Death	Reg. No 2007 34162
Dhu	ician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
200	dical	ALLENE MOBLEY	OCTOBER 18 2007 7:50 AM
Exar	niner		
Funer	al	CHARLES CO. NURSING & REHAB. LA PLATA  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	CHARLES  S. 8. Date of Birth  9. Birthplace (State or Foreign
Direct		261-48-6327 1 M 2 F 71 Yrs. Months Days Hours Min	(Month, Day, Year) Country) MAY 8,1936 FLORIDA
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryl -I sho	to	MD CHARLES WALDORF	1 ☐ Yes 2 ☑ No
death with the Maryland rms 23a or 28a-f show	Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ath wil	a G	2215 MILL HILL ROAD 20603	U. S. A.
er des	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue	Specify Yes or No- no Rican, etc.) 14. Race - American Indian, Black, White, etc.
036 urs aft	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No II Yes, Give X 1 ☐ Yes 2 ☑ No Specify: Year or Dates:	Specify: BLACK
INC 21215-0036  be filed within 72 hours after death with the Marylan lial Hygiene.  do other than "natural", or items 23a or 28a-1 show event, its Madical Examiner must be notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	16b. Kind of Business/Industry
within ene.	n de	Elementary/Secondary (0-12) College (1-4or 5+) life. DQ NOT use retired)	
d 2 filed v Hygie sthert			POULTRY COMPANY ame (First, Middle, Maiden Surname)
should be and Mental marked commatic even	To Be		HY JAMES
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	-		iural Route Number, City or Town, State, Zip Code)
		CYNTHIA BUTLER/DAUGHTER 2215 MILL HILL RD  20a. Method of Disposition (Name of	
Baltimore, bermit. Pages 1 a Department of Hec mportant: If Item iny injury or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	24 0 =
Baltimo permit. Pag Department Important: I		21 Signature of Emeral Service Licenses	21-07 LIVE OAK, FLORIDA
Balt permit. Departi Import	Suc	R. R. C. C. W. R.	AYMOND FUNL. SERVICE, P.A.
M. A. S.		23a. Part1. Enter the disease, or complications that caused the death. Do not geter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	AVE LAPLATA, MD 20646 Approximate Interval Between
Physicia			ancer Onset and Death
/Medic		resulting in death)  Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	
vision of Vital Records, P.O. Box 68760,— Attending Physician: The law requires that the death certificate be executed cleath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):	
587 icate h	dical		
Box 6i Bath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
o death	Physician/Med	in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  1 □ Yes 2 □ No  9 □ Unknown	Month Day Year
dS, P.O. BOX 6  ires that the death certific signed by the attending F d be detached for use as	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Records, he law requires ti e has been signe age 2 should be c	d by		1 Yes 2 No 3 Probably 4 Unknown
cord w require been si	lete		24a. Was an 24b. Were autopsy findings available
Re la The la te has age 2	Completed		autopsy prior to completion of cause of death?  1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ No
/ital	Be C	25. Was case referred to medical examiner?	nath (Check only one)
Of O	To.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing	Home 5 Residence 6 Other (Specify)
on ding th. After	tlon	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation M M M  28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
Division of Vital Rec tor Attending Physicien: The lavatile Geath. Director: After this certificate has in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Div bital or A bital or A ral Directled in by			
To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certiflier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and major of examination and/or investigation, in my opinion, death occurred at the time, date and major of examination and/or investigation, in my opinion, death occurred at the time, date and major of examination and/or investigation.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
Fo the Mithin Fo the	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		1006161	52 10/18/2007
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Le Co localolail Nan 2000
3	State	29b. Signature and title of certifier  DO0616 1  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ATYL KATHAL, SUITS # 304, 11350 Pembroo  31. Date filed (Month Cay, Year)  32 Registrar's Signature	ke Sg, walday, MD-20603

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** lores 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Home wood Narsing 4cme illiamsbort Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 🗷 F 21,1929 Director 215-26-8456 78 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he martified at 10a, State 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 X No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16224 Fairview Road 21740 USA Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chester G. Hawbecker Elsie M. Pensinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Holiday Martin/husband 16224 Fairview Road, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 23, 1 Burial 2 □ Cremation 3 □ Removal from State Mercersburg, PA Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. 21. Signature of Euneral Service License T. tues 47 N. Park Ave., Mercersburg, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician ause as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 = retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Montin, Day, Year) 29b. Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marviand / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 EDWARD-JON PIERRE OCTOBER 16 10:23 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 221 WEST MAIN STREET SHARPSBURG WASHINGTON Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Days Months Hours Min. 143-54-6596 50 New Jersey Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f sh notified 1 →Yes 2 No Director Maryland Washington Sharpsburg Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 21782 U.S.A. 221 West Main Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) 12 Furniture / Cabinet Maker Carpentry 7 is marked othe traumatic event, Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth M. Hogarth Edward P. Mundock ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Elizabeth L. Ramano (Sister) 221 W. Main St. Sharpsburg, Maryland 21782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October Smithsburg Crematory Smithsburg, Maryland 19, 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 Jeffrey Lee Davis MO1414 PER DVR Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** liobla /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate occur. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician a the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an page 2 s autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Afesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ 1 € 1 € 1 € 1 € 1 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. (Check only 2 Medical Examiner: 0

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

21215-0036

State Registrar one)

d title of certifie.

29b. Signature

DHMH 17 Rev 1/2001

MD

32 Registrar's Signature

29c. License number

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)
William F. Bodenheuman, no 9 Sout Paul Street, Bounsborns, no 21713

State of Maryland / Department of Health and Mental Hygiene 34165 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Louisa Olive Murray 5:00 P M 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Thomas More Nursing Home Prince George's Hyattsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1 □ M 2 🕅 F 574-46-0734 71 Yrs. Director 6-25-1936 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits MD Brentwood 1 √Yes 2 No Director Prince George's 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ms 23a or 7 3512 Varnum Street 20722 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 ☑ No Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) restaurant waitress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental in int: If item 27 is marked of Joseph John Winebrenner Estylynn Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health at: If item 27 is Dana Lynne-Marie Johns/daughter 3512 Varnum Street, Brentwood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial \_ 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metropolitan Crematory 10/6/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 MOINGI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years Arrythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Recurrent Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Months Multiple Decubitlii use as the burial-tra Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No for Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown cate has been signed it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebral Vascular Accident 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Chronic Obstructive Lung Disease 24a. Was an autopsy performed' death? 1 ☐ Yes certificate Dysphagia 2 □ No 1∐ Yes 2 🔀 No Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 41 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō Hospital 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many enstated. (Check only one) 29b, Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

altimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, OCT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tull, MD

10810 Darnestown Road, Suite 202, Gaithersburg, MD

20878

		1 - For State Registrar		ryland / Dep <i>Ce</i>			Death	d Mental	Hygier Reg. N		37	3416
Physic /Medi		1. Decedent's Name (First, Middle, La Richard	J.	Mea	ehan				of Death ber 7,	2007	Year	3. Time of Death 5:23 P
Examir	ner	4a. Facility Name (If not institution, given 13311 Harrison Avenue Sacial Security Number 2008	2		Ft. V	<i>V</i> ashir	_		F	c. County o	Georg	
Funeral Director		5. Social Security Number 078–22–3609 6. S	ex 7. Age	(In yrs. last birthday) 77 Yrs.	Months	r 1 Year Days	If Under 24 Hours M	in. April	of Birth th, Day, Yea	930		lace (State or Fore York
8a-f show officed st	ector	Maryland Prince Geo		10c. City, Town or Lo Ft. Wash							1	0d. Inside City Lim 1 ☐ Yes 2
23a or 2	Funeral Director	13311 Harrison Aver	nue		10f. Zip	20744			10g. C	itizen of W USA	hat Coun	try?
rai', or iteme Examiner m	5	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		Was Dece ff Yes, spe 1  Yes		ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes erto Rican, et	or No- c.)		, White,	an fndian, etc. hite
nal hygiene. od other than "natural", or iteme 23a or 28a-f show event. I'ra Madical Examinar must be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) 5+ <sup>Colfege (1-4or 5+)</sup>		dent's Usua kind of wo DO NOT us cher	al Occupa ork done d se retired	ation furing most of a	vorking	Pr	Kind of Bus ince Go chool S	eorge	County
h and Mental Hygiene. Fie marked other than "Feumatic event, the Mai	To Be C	17. Father's Name (First, Middle, Last)  Joseph Meehan						ise Ch	nerry			
of Health and Meritem 27 is marke other treumatic		19a. Informant's Name/Relationship (1 Clara Louise Meehan /					and Number or Avenue Ft					<sup>Code)</sup> 20744
nent or me int: if iten iry or oth		20a. Method of Disposition  1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Tionioral monit otato	20b. Place of Dispo cemetery, crer Ft. Lincol	sition (Name natory or o	ne of other place tery	10/1	Date 1/2007		Location - C	•	
Department of Health ar important: if Item 27 is eny injury or other treu		21. Signatur & Funeral Service Licen	lo f.	22	. Name an	nd Addres	s of Facility (	George P.	Kalas	Funera		ne PA
ysician fledical the pririal-transit the pririal-transit	dicai Examiner	fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATTLE to ue to (or as a compute to (or as a	onsequence of):	(an	dis	Vancla	nise	ane			Onset and Death
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pro					23d. Date Mont		y Day Year
gue pe c	þ	Part fl. Other significant conditions co	ntnbuting to death but r	not resulting in the un	iderlying ca	ause give	n in Part I.		Did tobacco		ute to the	cause of death?
e has be	Completed	or W.							Was an autopsy performed?	pri	or to com ath?	sy findings availal pletion of cause o
ficat or, pa	40				aC 80	Other	26. Pface of D	eath <i>Check</i> of Home 5X	777	0 (70)	40 41	
is certificat director, pa	00	25. Was case referred to medical examiner? 1 ⚠ Yes 2 ☐ No	Hospital:	2 FR/Outpatient		~	4 Lanursing	HOUSE STOLL	residence	6 UOther		
r: After this certificat e funeral director, pa	10 B	examiner?	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of fnjury		Bc. Injury Work′ 1 □ Y		28d. Desci	ribe how infu	ry occurred	i	
rai Director: After this certificat led in by the funeral director, pa	Certification; To B	examiner?  1  Yes 2 No  27. Mantural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day You	28b. Time of fnjury  - At home, farm, stre	M 28	1 □ Y , office	at ? es 2 ☐ No	28f. Locati City of	on (Street air Town, State	nd Number e)	or Rural	Route Number,
Funeral Director: After this certification by the funeral director	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day Yo	28b. Time of finjury  - At home, farm, stre Specify)  by knowledge, death armination and/or inv	M eet, factory,	1 ☐ Y	at ? es 2 \( \text{No}\)	28f. Locati City of	on (Street al	nd Number e)	or Rural	
he Funeral Director: After this certificately filled in by the funeral director	ledical Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day You building, etc. (Siscian: To the best of more: On the basis of ex.	28b. Time of finjury  - At home, farm, stre Specify)  by knowledge, death armination and/or inv	M eet, factory, occurred a estigation,	1 Y office at the time in my opi	at ? es 2 No es 2 No es, date and pla nion, death occ	28f. Locati City of	on (Street all r Town, State the cause(s me, date an	nd Number e)	or Rural ner as sta d due to t	ned. he cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 October Physician 17:43 Janelyn Ann Moore /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Pay, Year) Mar 07 1963 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 F 44 215-92-2085 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Westminster Director Carroll 10g. Citizen of What Country? 10e. Street and Number USA 21158 572 Whispering Meadows Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White Be Completed by 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Wells Fargo Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carole A. Byrnes ٥ James Patrick Moore III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1524 Scotland Avenue Chambersburg, PA 17201 Susan Mayer/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature of Funeral Service Frittsdfuneratione and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory
Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, Completed by Physician/Medical Examiner r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hetastatic Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOTPICE 1 Yes 2 No 1 [] inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Naturai Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO D65486 Keeled O. The 8, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marylan Broadway

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 9 2007

10

North

401

Registrar's Signature

EL-SHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 34168 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2007 12:10 p" October Joan Frances Myers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 💢 F July 22 1947 MD Director 60 216-54-3557 Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County th and Mental Hygiene. ?7 is marked other then "neturel", or Items 23s or 28e-f show treumatic event, it a Medical Evan, or must be toolifed at 1 ☐ Yes 2 XNo Westminster MD Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 118 Liberty Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify Soecify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Child Care Administrat 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Johnson Russell Martin Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 Liberty Street Westminster, MD Michele Wilson/sister If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/6/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 DaBurial 2 □ Cremation 3 □ Removal from State Sykesville, MD Lake View Memorial Gardens \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Printes Aftereradiv Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY **Physician** DAY disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760 Physician/Medical the attending p as IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 Live birth Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy HYPERLIPIDEMIA 2 No certificate I 1 ☐ Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No nerel Director: A filled in by the fu investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TRINA FRANKE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STMINSTER RD REISTERSTOWN SUITE 101 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 2007 Registrar DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylan	d / Depa <i>Cei</i>	artment of H	lealth and <i>Death</i>	Mental Hy	giene (	7 (	34169
1			Decedent's Name (First, Middle	e, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Dorothy P. M	cCaslin					Octobe	_3		310 PM
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, o	r Location of Dea	ith	4c. County	of Death	
			Harford Memo					de Grace		Harfo		
	Funeral		5. Social Security Number 213-34-2094	6. Sex 1 ☐ M 2 🕅 F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hr. Hours Mir	. (Month, D	ay, Year)	9. Birthpla Countr	ace (State or Foreign
	Director		Usual Residence of Decedent		12				March	22, 1935	ria	ryland
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10	d. Inside City Limits
	the Marylan r28e-f ehow notitied at	ctor	Maryland	Cecil		C	onowingo					1 ☐ Yes 2 X No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Count	ry?
	death with the Maryland ma 23a or 28e-f ehow must be notified at		1331 Dr. Jac				219			USA		
		Funeral	11. Marital Status	Armed Fo		S. 13.	Was Decedent of his Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	Blac	- America k, White, e	
28	rs aft	by F	1 ☐ Never Married 2 📉 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	ve -		1 ☐ Yes 2 🎇 No	Specify:		Specify	Wh:	ite
510	within 72 hours after ene. then "naturel", or Ite he Medical Examina		15. Deceder	it's Education		16a. Dece	dent's Usual Occup	pation	advina	16b. Kind of Bu		
- 5	thin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College (		life.	kind of work done DO NOT use retire	d)	orking			
2	filed wi Hygien other th	Con	12			Home	emaker			Own I		
1 0 8 0 1	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, Italia	Be	17. Father's Name (First, Middle,						ame (First, Middle ce Has1be	a, Maiden Sumam	θ)	
8	ges 1 and 2 should be 1 tof Health and Mental I II item 27 is marked o or other treumatic eve	To	William Grac  19a. Informant's Name/Relations			10h Mailie	ng Address (Street				State Zin (	Codel
→ E	d 2 sl th an 7 le r		Norman L. Mc		chand	1	331 Dr. J					
- 9	1 and 2 Health tem 27 other tr		20a. Method of Disposition	oasiii/ iius	20b. P	face of Dispo	sition (Name of		Date	20c. Location -		
Š	ages ant of nt: If it		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (5		State		natory or other pla ard Funer	. 1	)-11-07	Rising S	Sup. 1	Marvland
Paltimore	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service		10.	22	2. Name and Addre	ess of Facility				
ä	\$ 9 E 8		1	7		R 11	T. Foar 1 S. Que	d Funera en Stree	al Home, et. Risi	P.A. ng Sun, l	4D 219	911
			232. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of	caused the death							Approximate Interval Between
	Physician		Immediate Cadse (Final disease or condition resulting in death)	, S	ever	0 /5	22QS1	<				Onset and Death Superior
	/Medical Examiner		resulting in death)		(or as a consequ		4					2
rain	LAdminici	-	Sequentially list conditions		staid	int o	liffic: L	و ده	1+15			Sweeks
100	pet nsit	niner	Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>4 500</b> 10	(or as a consequ	derice or).	70					
5	execunand nand	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):						
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Pat	The law requires that the death certific the has been signed by the ettending page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnanc	y		23d. Dat	e of deliver	y Day Year
- 0	e death	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□ Unkn	nant at time of de lown	eath 5	Other (specify)			WIO	101 -	Jay Toai
20	that the de ed by the detached	F.	Part II. Other significant conditi	ons contributing to d	leath but not resi	ulting in the u	nderlying cause on	ven in Part I	23e. Did	tobacco use conti	ribute to the	a cause of death?
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200	w requir been si should	ete	2: 2	1 .1 -	A 1	- (	tasis	3.4.10	24a. Wa	s an 24h V	Vere auton	sy findings available
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= 0	ilcian: Th certificate rector, pag		Drabetes 12 25. Was case referred to medica	elletons	ty se I			26 Place of D	1 ☐ Yes eath (Check only		☐ Yes 2	2 LI No
>	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 22 No	Hoppital	Inpatient 2	ER/Outpatier	nt 3 DOA Ott	200		idence 6 Oth	er (Specify)	)
Ccaslin	ding Ph After th funeral	٦	27. Manner of Death  1.☑Natural 5 ☐ Pendi	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	f 28c. Inju Wo	ry at rk?	28d. Describe	how injury occurr	ed	
$\frac{1}{2}$	Attending ir death. ector: Alter by the fune	catic	2 ☐ Accident invest	igation			M 1	Yes 2 No				
MCCaslin, Dorot	or Attenester deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289, Place	e of Injury - At ho ling, etc. (Specif)	ome, farm, sti /)	reet, factory, office			(Street and Numb own, State)	er or Rural	Route Number,
	pital purs e erat [	S	29a. Certifier 1FKCertifyi	ng Physician: To the	a bast of my kno	wledge deat	h occurred at the ti	me date and place	ce, and due to the	a cause/s) and ma	nner as sta	ated
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical one)	Examiner: On the b	pasis of examination of states.	tion and/or in	vestigation, in my	opinion, death oc	curred at the time	, date and place,	and due to	the cause(s)
_	Fo the	₹ Ø	29b. Signature and title of certific	*			29c. Licens	se number		29d. Date signe	(Month, D	Day, Year)
	, > = 0		XII	-			Dog	53569	~	October	~ &	2007
	/		30. Name and led iss of order	in a second or	e of death (Item	1 23a) (Type,					- 1	
	0		Jeffrey Thomps				Ave., Ha	vre de G	race, MD	21078		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year OCT 1 1 2	007 <b>1</b>	Registrar's Signa	ture	W					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #8.perFH.g873, 11/9/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OCTOBER 2007 5:41 MYERS VIRGINIA LILLIE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1930 April 5, 2007 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days 1 ☐ M 2 🗓 F 217-28-6985 77 Maryland Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Maryland | Frederick Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number States 13866 Old Annapolis Rd. 21771 United 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Nursing Assistant State Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) James Johnson Lucille Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13866 Old Annapolis Rd./ Mount Airy, MD Jeroline Williams /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Simson U.M. Cemetery 10/11/2007 Poplar Springs, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8 E. Ridgeville Blvd./Mount Airy, MD 21771 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Day Gastrointestinal Bleed Due to (or as a consequence of): Day Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Years End stage Renal Disease Due to (or as a consequence of): IF FEMALE 23d. Date of delivery opic pregnancy Month er (specify) 23e. Did tobacco use contribute to the cause of death? ying cause given in Part I. 1 Yes 2 No 3 Probably 4 Inknown Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ✓ ✓ autopsy performe 2 4 26. Place of Death Check onl one Hospital:

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

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Important: If iter
any Injury or oth

Hygiene.

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Director

Funeral

Completed by

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Physician/Medical

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Certification: To

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filled in 24 hours a Hospital

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

physician and stran tran attending p for use as as ed by the a signed t has page 2 certificate After this

the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Physician:

or Attending

death.

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within 24

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pr pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ecto 5 ☐ Oth
art II. Other significant conditions	contributing to death but not resulting in	the underly

Diabetes

25. Was case referred examiner? 1 ☐ Yes 2 ☐ W	_
27. Manner of Death	5 C D ii-

5 ☐ Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

1 Dipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

00062223

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRAYCEN BOLFROY, MD, 1967. F. DRIVE, PLEOFFICK, MO - 21702. MD

Registrar

31. Date filed (Month, Day, OCT 1 1 2007

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed

9 2007

			Please	Type or Prin					•		•		
			For	State of Ma	aryland	/ Depa	artment of H	lealth and	Mental Hy	giene	:		
		•	State Registrar			Ce	rtificate of	Death		Reg. No	2007	34	172
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Li		sat	50	ς		2. Date of De Month	eath Day	2007	3. Time of	Death M
	Examin	- 2 -	4a. Facility Name (If not institution, gi		i	1.0		or Location of Deat	h	4c.	County of Deat	h	( ^
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	Funeral			Sex 7.Ago 1XXIM 2□F	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	ay, Year)	Co	hplace (State o untry)	r Foreign
	Director		228-38-8728	Tapm 201	74	Yrs.			Aug. 18	, 19:	33 No	th Car	olina
	and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside Cit	y Limits
	Aaryt f sho ed af	ō	MD Wicomio		Doma							1 X Yes	2 □ No
	the N 28a- notiff	Director	MD Wicomic  10e. Street and Number	:0	Pars	onsbu	10f. Zip Code			10g. Cit	izen of What Co	untry?	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Ö	7146 Wainwright	Avenue			21849			· ·	U.S.A.		
	ns 2;	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No	)-	14. Race - Ame		
10	riter o	Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ N	No 1951		if Yes, specify Cub		to Rican, etc.)		Black, White		
980	urs a al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1954	_	1 □ Yes 2 🔀 No	Specify:			Specify: V	vhite	
Õ	2 should be filed within 72 ho and Mental Hygiene. is marked other than "natur aumatic event, <u>the Medical I</u>	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	pation	rkina	16b. K	ind of Business/	Industry	
215	thin 7 an "r Med	adr.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	kind of work done DO NOT use retire	ed)	ikiig				
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Б	be file tal Hy d oth event	Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's Na.	me (First, Middle	, Maiden	Surname)		
<u> </u>	should to and Ment marked umatic	ပ္	Peter Mack Matsa	tsos				Maggie	Mae Owe	ns			
Maryland 21215-0036	es 1 and 2 should be of Health and Ment Item 27 is marked rother traumatic e		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	t and Number or R	ural Route Numl	er, City o	or Town, State, 2	Zip Code)	
≥	and ealth n 27 ner tr		Dorothy T. Matsa	tsos			Wainwrig	ht Ave.				21849	
ore			20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3	Removal from State	cer	netery, cre	osition (Name of matory or other pla		Date		ocation - City or	Town, State	
Ē	Pag ment ant: ury		4 ☐ Donation 5 ☐ Other (Spec		Crem		of Delma		12,2007	Del	mar, De	laware	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensee		S	2. Name and Addre hort Fun	ess of Facility eral Home	2				
Ш	205 # 9		- Juni				hort Fund 3 East G				DE 19	940	
			23a. Part1. Enter the disease, or con shock, or head failure. List onl	pucations that caused one cause on each lir	the death. ne.	Do not en	ter the mode of dyi	ing, such as cardia	c or respiratory a	arrest,		Approximate Interval Bet Onset and I	ween
	Physician		immediate Cause (Final disease or condition	Ren	al	Ca	ncar					Oriset and L	Jean
7	/Medical		resulting in death)	Due to (or as	a conseque								
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	p #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ence of):							
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9 ×	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Medic	IF FEMALE:	23c. if yes, outcome	of pregnance	PV.					00 l D		
Box	attendation of the contraction o	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal d	leath 3	☐Ectopic pregnand ☐ Other (specify) _	су			23d. Date of del Month	*	r'ear
	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time of dea	aui 5	Other (specify) _						
P.0	that the ed by detac	Ph	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the u	inderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of d	leath?
ds,	w requires tha been signed I should be det	by							1 🗆	Yes 2	No 3□P	robably 4 □l	Jnknown
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Ĕ	ding F h. After funeri	on:	27. Manner of Death Natural 5 Pending	28a. <b>If</b> ate of Inju	y Year)	28b. Time o Injury	Wo		28d. Describe	now inju	ry occurred		
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Ц	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi		29a. Certifier 1 Certifying F	hysician: To the best	of my knowl	lodgo dos	th accounted at the t	time, data and place	o and due to the	2 001100(0	and manner of	e etatad	
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	nd in		30 Name and address of person who	completed cause of d	eath (Item 2	zsa) (Type	PINO BO	0x1722	Salist	<i>)</i>	WD a	11802	_
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month NICHOLS 12:00PM 10 **Physician** 2001 AMELIA 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GENECES CLINTON Home. OAKS NURSING BRADFORD tf Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 09-04-1919 7. Age (In yrs, last birthday).
Yrs. 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 F 259-32-6435 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Evantiner must be notified at 1 Yes 2 No PRINCE GEORGES FULL WASHINGTON Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ROAD CANNON USA 1104 by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) HEIVATE f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BUTCHER 12+h 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARMAN Pages 1 and 2 should be nent of Health and Mental NICHOLS DELLA BEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FORTWASHING NO JONE BROWN NIECE 1104 OLD CANNON RO AILUL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 0 = Burial 2 Cremation 3 Removal from State Philadelphia, PA MOUNT PLACE CEMERREY 10/15/07 permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 814 UPSHUR STAW DC 20011 BLANCHI FUN SOLV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Therosclenotic (andio Varalan **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed s certificate has l lirector, page 2 s 1 Yes 2 No To the Hospitel or Attending Physician: 26. Place of Death (Check on one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ို 1 ☐ Yes 2 ☑ No 3□ DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: ./ completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0045363 10-10-2007 livingston N + 101 fort we highon MD 2014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ibARONS, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 1 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) october 6, 2007 Pear **Physician** 7:25 Maria Herminia Ovalles /Medical 4c. County of Death Carroll 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Westminster 652 Spring Meadow Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Dominican Hours 1 □ M 2 🔀 F 092-58-0026 93 1914 Jan 6, Director Republic Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at Westminster 1 ☐ Yes 2 No Carroll Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 frem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 652 Spring Meadow Drive Dominican Republic Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after Hygiene. Specify Dominican 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1X Yes 2□No white Specify: þ 3 ₩ Widowed 4 Divorced Republic Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Dionisio Ovalles Juana Marrero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 652 Spring Meadow Drive, Westminster, MD 21158 Bettania Waight, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of . Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 10/9/2007 Finksburg, MD Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 CU. 23a. Part1. Enter the disease, or complications the squeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examine The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physici**ar** IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has s certificate has irector, page 2 performed? 1∏ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To this after death.

I Director: After this d in by the funeral d 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature itle of certifier

wit

State Registrar

31. Date filed (*Month*, *Day*, *Year*)

OCT 1 0 2007

30. Name and address of person who

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Aparle

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Min.

Annapolis

Months Days

7. Age (In yrs. last birthday

Month

October

07

2007

Anne Arundel

14. Race - American Indian,

4c. County of Death

12:42 P™

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Virginia

- 4		un	er	2
п	D	ire	er:	0
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Populations of Booth and Montel Business	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any Injury or other traumatic event, the Medical Examiner must be notified at	9000
10 K3 KM	Phy /N Exa	/Sid led am	cia lica ine	ra
8760,	sate be executed	hysician and	the buriat-transit	

Physician

/Medical

**Examiner** 

Margarett Earle Phillips

Spa Creek Center

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

1 □ M 2 T F

8. Date of Birth (Month, Day, Year) 08/24/1920 215-12-9930 87 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 United States 111 Cardamon Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Be Earl Monds Whitehurst 19a. Informant's Name/Relationship (Type. Print) Charles E. Phillips/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2007 Maryland Veterans Cem. 21. Signature Junior Vice Licensee Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical Division or Vital Records, P.O. Box 6 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death ed by the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed page 2 10 25. Was case referred to medical examiner? Be 1 □ Yes 2<del>(1</del> Po Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director; A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29b. Signature and title of 1)32034 30. Name and does of person who completed cause of death (Item 23a) (Type, Print) Gary J. Sprouse, M.D. 2108 DiDonato Drive, Chester, Maryland 21619

Black, White, etc. Specify: White 16b. Kind of Business/Industry Home 18. Mother's Name (First, Middle, Maiden Surname) Ethel Blanche Rushbrooke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Cardamon Drive, Edgewater, Maryland 21037 20c. Location - City or Town, State Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. M 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 26. Place of Death (Check only one) Other: ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dav. Year)

31. Date filed (Month, Day, Year)

OCT 0 9 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:25 a M 5, 2007 Robert Barrett Pond, Sr. October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec 1, 1917 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 15€M 2□ F 89 714-18-1466 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐Yes 2 No Westminster Director Carroll Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 299 Ridge Road USA by Funeral items 2 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced WWII "natural" al Hygiene. J other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Professor 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Josephine Barrett Charles E. Pond ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. 299 Ridge Road, Westminster, MD 21157 Mary W. Pond, wife 20b. Place of Disposition (Name of South 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/10/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) A SCUP /Medical Due to (or as a consequence of): Examiner ucune. Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dave Heur 1 ☐ Yes 2K1 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: Fo the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated. 29a. Certifier death occurred at the time, date and place, and due to the cause(s) and manner as stated.

d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29c. License number 29b. Signature and title of certifier

WSL/A WSL/A

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

OCT 0 5 2007

30. Name and address of person who completed caus

23a) (Type, Print)

			1 = For State Registrar	State of Maryland / Depa	rtificate of Death		2007 34177
			1. Decedent's Name (First, Middle, Last)	)		2. Date of Death	3. Time of Death
	Physici		Milford Handy Post	-lev		Month	Day 2007 07:48 M
	/Medio Examin		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Deeth
	LXAIIII	ici	9166 Peerless Road		Bishopville		Worcester
3	Funeral		Social Security Number 6. Sep.	x 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	
k	Director		220-26-2191 <sup>18</sup>	M 2□ F 77 Yrs.	Months Days Hours Min.	Sept 22	
	D		Usual Residence of Decedent			TOOPE 227	
	nylan how		10a, State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
	e Ma	Director	MD Worceste	er Bishopvil	.le		1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street and Number		10f. Zip Code	100	. Citizen of What Country?
	death with the Maryland ms 23a or 28a-f show Frount to notified at		9166 Peerless Road	l	21813		USA
	dea dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	d within 72 hours after death with the Marylar jain. Ir then "naturat", or items 23a or 28a-1 show the Madical Examiner must be notified at		1 Never Married 2 Marned	1X Yes 2 □ No Army	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
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Maryland 21215-0036	2 e a 2		19a. Informant's Name/Relationship (Ty		ng Address (Street and Number or Ru		
	s 1 and f Health item 27 othar to		Priscilla Postley/	daughter 1200-	4 Campbelltown Rd	Bishop	ville, MD 21813  c. Location - City or Town, State
0	m 0		20a. Method of Disposition  1 DBurial 2 Cremation 3 R	Removal from State cemetery, cren	matory or other place)		•
altimore,			*4 □Donation 5 □ Other (Specify)			8/2007 B	ishopville, MD
Bai	permit. Departr Importa eny inje		21. Signature of Funeral Service License	22 L	Name and Address of Facility  N. Watson Fu	neral Hom	<b>a</b>
	40 ≥ • a		- Jalana Bua	ications that caused the death. Do not ent	618 West Rd., Sal	isbury, M	21801
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused the death. Do not enti- ne cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
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X On	ath ce ttend	an/Med	23b. Was decedent pregnant		Ectopic pregnancy		23d. Date of delivery Month Day Year
J. Box	e death certific the attending p ned for use as:	sician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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л О	ss that the d gned by the se detached	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions cor	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Other (specify)		Month Day Year
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) PATRICIA ANN RUMSEY $\mathbf{P}^{\,\mathsf{M}}$ 08 2007 7:02 OCTOBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 💢 F 219-56-6636 56 AUG 30, 1951 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No BEL AIR HARFORD MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 **USA** 2731 FORGE HILL ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes 2 X No f Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: BLACK If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FAST FOOD RESTAURANT COOK 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERNARD WILLIAMS VIOLA MABEL RUMSEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 WILLOW BEND DRIVE, EDGEWOOD, MARYLAND 21040 VICTORIA RUMSEY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 10/16/07 CLARKS UNITED METH. BEL AIR, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR CIRRHOSI Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS 1 Tes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? Ho 1 Yes 2 No

Physician /Medical Examiner

that the death certificate be executed

The

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f shor must be notified at

Director

Funeral

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Completed

Be

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death with the Maryland

and 2 should be filed within 72 hours after ealth and Mental Hygiene.

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permit. Pages 1 and 2:
Department of Health a
Important; If Item 27 is
any injury or other trau

sician and burial-trans

signed by

Physician/Medical ģ Completed

Examiner attending physician for use as the buria has page Be P Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

			m 0 1 1 1000		room only one,	
spital: npatient	2 ER/Outpatient	3□ DOA	Other: 4 1	lursing Home	5 ☐ Residence	6 ☐Other (Specify)
28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury		Injury at Work? 1□Yes 2□	28d.	Describe how inj	

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and the of certifier

5 Pending investigation

6 Could not be determined

OCT 1 1 2007

DOUS 6 296

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hesapeake Dr. Bel Air, mp 21014 lason Birnbaum, M.D. 520Upper 31. Date filed (Month, Day, Year)

State Registrar

within 24 hours after death To the Funeral Director:

Hospital

To the

filled in by

completely

Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		artment of He ertificate of E			Reg. No. 7	07 31.17
			1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	3. Time of Death
· Nami	Physicia /Medic		CLARA C	SHROU'			OCTOBER		07 10:30A
	Examin	er	ta. Facility Name (If not institution, give street and number)	T	4b. City, Town, or FREDERICK			FREDE	
		9	FREDERICK MEMORIAL HOSPITA  5. Social Security Number (6. Sex Age	الــــــــــــــــــــــــــــــــــــ	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Forei
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	the M 28a-f	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country?
	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examiner must be notified at		895 Pontiac Avenue		2170	l		U.S.	.A.
	death	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	. Was Decedent of His If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Bla	ce - American Indian, ick, White, etc.
92	s after or Ite	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 MAN If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specii	y: White
Ş	hours tural' al Ex	q pa	15. Decedent's Education	16a. Dece	edent's Usual Occupa	ition		16b. Kind of B	Business/Industry
15	in 72 in "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	(Give	e kind of work done d DO NOT use retired	uring most of work )	ring		_
212	d with giene er tha , the I	mo m	12	Ho	memaker			Own I	
ng	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)  Melvin Roy Nusz, Sr.			18. Mother's Nam	e (First, Middle a B. Su		me)
Z	d Men marke	၉	19a. Informant's Name/Relationship (Type. Print)	19h Mail	ling Address (Street a				n. State. Zip Code)
Ma	nd 2 sl Ith an 27 is r traur		Eugene L. Shrout, husband	l l	Pontiac A				
ē,	s 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	20b. Place of Disp	ematory or other plac	e) !	Date		- City or Town, State
E	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Smithsb	urg Cremator	y Oct. 21,	, 2007	Smiths	burg, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign role of Fineral Service Lic insee	MOO255 1	<sup>22.</sup> Keeney a LO6 East C	nd Basfo: hurch St	rd PA F	uneral lerick,	Home MD 21701
1			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Anoxic a consequence of):	Encep	halopa	Hy		Oliset and Death
	/Medical Examiner		resulting in death)  Due to (or as a	a consequence of):		1 /2+	Para tis	и	
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or Vital Records, P.O. Box 6	lospital or Attending Physician: The law requires that the death certificate after death.  Funeral Director: After this certificate has been signed by the attending I ely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   Zervo   Yes 2   Investigation    25. Was case referred to medical examiner?  1   Yes 2   Investigation    27. Manner of Death 1   Natural   5   Pending investigation    29. Accident   Suicide   6   Could not be determined    28e. Place of injudicing, etc.	pf pregnancy 2 Fetal death 3 t time of death 5  ut not resulting in the  ut not resulting in the  ent 2 ER/Outpati  rry 28b. Time Injury ury - At home, farm, s.c. (Specify)  of my knowledge, de of examination and/or	ient 3 DOA Other (specify)  underlying cause giv  ient 3 DOA Other of 28c. Injury  M 1 Street, factory, office eath occurred at the tir investigation, in my of	en in Part I.  26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No  me, date and place	24a. War aut per 1 Ves ath (Check only lome 5 Res 28d. Describe 28f. Location City or To	tobacco use cor  Yes 2/2/No  s an 24th ppsy ormed? 2/2/No  one) idence 6 0 how injury occi  (Street and Nurr wn, State)  e cause(s) and s a, date and place	Anoth Day Year  Intribute to the cause of death?  3 Probably 4 Unknown or to completion of cause death?  1 Yes 2 No  Other (Specify)  Figured  Indian Route Number,  Indian Rout
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or Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending I to the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions contributing to death by the pregnant at 9   Unknown  25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Impatie   1   Impatie   28a. Date of Inju (Month, Date   1   Impatie   28a. Place of Inju (Month, Date   28a. Place of Inju (Mon	pf pregnancy 2 Fetal death 3 time of death 5  ut not resulting in the  ut not resulting in the  pent 2 ER/Outpati  gry 28b. Time Injury ury - At home, farm, sc. (Specify)  of my knowledge, de of examination and/or ated.	ient 3 DOA Other (specify)  underlying cause giv  ient 3 DOA Other (specify)  a underlying cause giv  ient 3 DOA Other (specify)  y M 1 Street, factory, office on the tire investigation, in my office on the tire investigation.	26. Place of Deaer: 4 Nursing Hyat k? Yes 2 No	24a. War autoper 1 Yes ath (Check only lome 5 Res 28d. Describe 28f. Location City or To	tobacco use cor Yes 2 2 No s an 24th ppsy ormed? 2 No one) didence 6 O how injury occi (Street and Num own, State)  e cause(s) and i o, date and place	Annth Day Year  Intribute to the cause of death?    3

DHMH 17 Rev 1/2001

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AMEND TTEM#20b perFH C872 10/24/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:07 PM OCTOBER 18 2007 LAURA ELIZABETH SCHWIEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF GENESIS WALDORF CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or DEC . 19, 1908 MARYLAND 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🙀 F Yrs 98 Director 214-28-8892 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2√2 No Examiner must be notified Director MD. CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 4140 OLD WASHINGTON ROAD U.S.A.

14. Race - American Indian, 20602 death Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify. Specify: WHITE à 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) MOTORCYCLE GARAGE BOOKKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۵ HARVEY P. CONNER BLANCHE GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN TIERNEY/DAUGHTER 16900 Cedar Forest Rd.Brandywine, MD20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM. GRDNS October 24,2007 WALDORF, MARYLAND 21. Signature of Saneral Service Licenses 22. Name and Address of Facility M00479 RAYMOND FUNL.SERVICE, P.A. 20646 AVE LAPLATA, MD Part1. Enter the disease, or complications the woused the death. Do no e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) pe Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9□Unknown 9∏Unknown ۵ as been signed be 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page certificate 2 No Vital 1⊟ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 ☐ Yes 1 Inpatient ÷ 2 □ ER/Outpatient 3□ DOA Division or After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending Injury 1 Natural thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 24 Medic 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30, Nam and address of person who completed cause of death (Item 23a) (Type, Print) LINE CELFER WALDUF, MA .0 (DC)

Registrar

State

31. Date filed (Month, Day, Year)

OCT 2 4 2007

ELASS

22. Registrar's Signature

## Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Marylar			of Health and of Oeath		giene 0 0	7 34181	
Physi	ician dical	1. Decedent's Name (First, Middle, Last) Florence M.	S	chrecor	ngost		2. Date of Dea Oct 19,	2007	3. Time of Death	
Exam		4a. Facility Name (If not institution, give str Frostburg Village Nu				Town, or Location of Dea tburg	th	4c. County of Allegar		
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs	last birthday) Yrs.	If Under Months	1 Year   If Under 24 Hrs Days   Hours   Min		h	9. Birthplace (State or Foreign	
Aaryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  MD Allegany	10c. C	ity, Town or Lo Cumb	erlan	d			10d. Inside City Limits  M☐ Yes 2☐ No	
death with the Maryland rms 23a or 28e-f ehow I must be notified at	Funeral Director	10e. Street and Number  1 Baltimore St. Apt.	414		10f. Zip	<sup>Code</sup> 21502		10g. Citizen of What Country?		
Idally idally 2.12.13-0030 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or tiems 23a or 28e-f ehow aumatic event, the Medical Examinar must be notified at	d by Funera		2. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates:	i	Was Deced if Yes, spec	ent of Hispanic Origin? (! ify Cuban, Mexican, Puel X I No Specify:	Specify Yes or No- to Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: white		
within 72 hours after line. **.** within 72 hours after line. **.** within **.* within **.** within **.** within **.** within **.** within **.* within **.** within **.** within **.** within **.** within **.* within **	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	kind of woi DO NOT us	I Occupation is done during most of wo e retired)	-	16b. Kind of Bus	·	
id be filed lental Hygi ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) James Taylor				18. Mother's Na Florence	me (First, Middle,		3)	
E, Maryid  1 and 2 should  Health and Men  6 m 27 is marke  ther traumatic		19a Informant's Name/Relationship (Type Susan Jackson	daughter	19b Mailir 6633	Harves	(Street and Number of Fish Ridge Ave. N	E Canto	n, City or Town, S <b>n</b>	ÖH 44721	
		20a. Method of Disposition  1  Burial 2  Cremation 3 Re 4  Donation 5 Other (Specify)		Place of Dispo cemetary crer arpelli Fui		ome, P.A.	Date 10/20/2007		Oity or Town, State  OWN MD	
permit. Pages Depertment of Important: If it	DUCE	21. Signature of Funeral Service Licensee		. 22		r <del>pelli</del> rFuneral ⊢ Virginia Avenu		and, MD 2	1502	
Certificate be executed  Certificate be executed  Certificate be executed  Certificate be executed  Certificate and  Certificate as the burial-transit  Certificate  Certifica	al	23a. Pan Enter the disease, or confliction on heart failure. List on one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.		quence of):		a of dying, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death  ONSET 6 MONTHS	
of the last	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3	⊒Ectopic pr ☑ Other (sp			23d. Date Mor	e of delivery th Day Year	
requires that the de- een signed by the a	ρ	Part II. Other significant conditions conti	ributing to death but not re	sulting in the u	nderlying c	ause given in Part I.			ibute to the cause of death?  3 Probably 4 SUnknown	
nec The law te has b age 2 sl	Completed							psy pred? d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No	
cian: entifica sctor, p	Be	25. Was case referred to medical examiner?				1.	eath (Check only o	ne)		
ding Phy After this funeral d	tlon: To	27. Manner of Death 1 St Natural 5 Pending	spital: 1 Inpatient 2[ 28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injury at Work?	Home 5 Resid	dence 6 Other		
DIVISION  To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str ify)			28f. Location (S City or Tox	Street and Number vn. State)	er or Rural Route Number,	
Mospite 124 hours 16 Funere	edical C		cian: To the best of my kr er: On the basis of examir and manner stated.							
To the vithin 2 To the complet	M	29b. Signature and title of certifier				. License number		_	(Month, Day, Year)	
		) 9that	•		1	16907		OCTOBÉR	19, 2007	
4	State	30. Name and address of person who con DR. HARST S. 3	SIDHU 92 32. Registrar's Sig	5 BISH	Print) HOP (L	MISH RD.	CUMBER	RUMO, M	nd 21592	
Regi		001 % 4 2007	state in si	A STATE OF	Comment					

State of Maryland / Department of Health and Mental Hygiene 2007

		1 - State of Mar State Registrar		rtificate of D	eaith and Mei Death	ntai mygiei Reg.	2007	34182
Physicia	-	1. Decedent's Name (First, Middle, Last)  Rebekah Ramsburg Sh	afer			Date of Death Month tober 17	Day 2007	3. Time of Death 6:10 PM M
/Medica Examine	- 2	4a. Facility Name (If not institution, give street and number) Citizens Care & Rehabilitation Cen		4b. City, Town, or l	Location of Death	4c. County of Death Frederick		
Funeral Director		5. Social Security Number 217–48–1496 6. Sex 1 M 2 M 2 M	(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	g. Birthp	lace (State or Foreign		
Maryland a-f show iffed at	ctor		Oc. City, Town or Lo Frederick				1	0d. Inside City Limits 1 □Yes 🋂 □ No
uth with the 23a or 28 ust be not	ral Dire	10e. Street and Number 8926 Walter Martz Road		10f. Zip Code	702	10g.	Citizen of What Coun	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☐XNo	spanic Origin? (Specit n, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036 ad within 72 hours af giene. er than "natural", or t, the Medical Exami	omplete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) [omemaker	tion uring most of working	16b	Own Home	-
Maryland 2121 nd 2 should be filed within nd 2 should be filed within th and Mental Hygiene. Z7 is marked other than traumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) Clinton Reverdy Sunday	,		18. Mother's Name <i>(F</i> Elsie	irst, Middle, Maid Irene Ra		
Maryla and 2 should safth and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print) Mrs. Nancy Routzahn, daughte		ng Address <i>(Street al</i> Walter Ma	nd Number or Rural F artz Road.	Route Number, Ci Frederi	ity or Town, State, Zip ick, MD 21	702
Baltimore, bermit. Pages 1 a Department of Hee mportant: If Item any Injury or othe		20a. Method of Disposition  1 Neurola 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		E. Location - City or To Frederick,				
Baltimo		21. Signar to of Funeral Service Literatee  MOC	$\frac{2}{1}$	Keeney at Keeney at 06 East C	hd Basford hurch St.,	PA Fund Freder	eral Home ick, MD 21	701
Physician /Medical Examiner per property propert	Examiner	23a. Part1. Enter the disease, or complication, that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ane	Approximate Interval Between Onset and Death				
Box 68760, E eath certificate be executed attending physician and for use as the burial-transit	ledical	d	consequence of):			-		
ords, P.O. Box 68760, Frequires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ■ No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
w requires that the de been signed by the should be detached	ò	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
S b aw	Completed					24a. Was an autopsy performed 1□ Yes 2	prior to co	psy findings available mpletion of cause of 2
Or Vital Physician: T this certificate ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	Othor	r: Nursing Hams		e 6 □Other (Specif	
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day 1) 2 Accident investigation	28b. Time o	f 28c. Injury Work	at 280	d. Describe how i		<i>y)</i>
Division tal or Attending rs after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc.	- At home, farm, str (Specify)	reet, factory, office	28f	. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
Div	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or in	h occurred at the time exestigation, in my op	e, date and place, and pinion, death occurred	d due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
To th withir To th comp	Me	29b. Signature and time of ceptifier		29c. License	number 12971		Date signed (Month, ctober 18,	
n		30. Name and address of person who completed cause of dea Robert L. Kaufmann, M.D., 3			et, Freder			2007
State Registra			s Signature		I Cuel		21101	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30 AM Dale Ray Shreve Deptember 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number nenera mor Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Director 33 Sept. 16,1974 Cumberland, MD 214-90-3372 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 □ No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12 Arrowship Road 21222 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Saltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🎇 No Specify. Specify: 3 ☐ Widowed 4 Divorced Year or Dates White Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Self employed stone mason Masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Terence Shreve Barbara A. Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Puffinberger/Mother 1186 Round Hill Road Winchester, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o once. Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens 2007 Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due wor as a consequence of): **Physician** disease or condition /Medical resulting in death) Examiner Spirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2. No After this certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

29b. Signature and title of certifier

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

the

Registrar DHMH 17 Rev 1/2001 29c. License number

29d. Date signed (Month, Day, Year)

Michael W. Soul 07-04503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		State of Maryland / Department of Health and Mental For State  Certificate of Death		Reg. No. 2	007 34184			
Physician		egistrar . Decedent's Name (First, Middle,Last)	2. Date of De Month		3. Time of Death			
Medical Examine	er	Michael W. Soul	June 12,	2007	0930 Hrs			
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 4516 Mannasota Ave. Baltimore		4c. County of				
Funeral	5	Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		Birth(MM/DD/YYYY)	9. Birthplace (State or unk			
Director		<b>219–50–5508</b>   1   X M 2   F   55   Yrs.   Months   Days   Hours   M	July	25, 1951	Countrillaryland			
	-	Jsual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
ow any		0a. State 10b. County 10c. City, Town or Location MD Baltimore			1 X Yes 2 No			
Aaryland 28a-f show 1 at once.	5	0e. Street and Number 10f. Zip Code		10g. Citizen of What Country?				
the Maryland a or 28a-f sh lifted at ones		4516 Mannasota Avenue 21213		USA				
death with the Maryland or items 23a or 28a-f sho must be notified at once.		1. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? ( Armed Forces? 1171/2   If Yes, specify Cuban, Mexican, Puer		No- 14. Race White	- American Indian, Black,			
or items 23		Never Married 2 Married 1 Yes 2 X No	no rican, etc.,					
s after oral",	<u></u> }-	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	of work done		white siness/industry unk			
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5-0 lled willed will Hygie		17. Father's Name (First, Middle, Last)  18. Mother's Name	me (First, Middle	e, Maiden Surname)	<del>-unk</del> -			
D 21215-00; should be filed with and Mental Hygiene and Mental Hygiene in aftic event, the Mental To Bo Communication and the Mental Englishment and Mental Engl	e l	William James Soul Helen	Marie Hi	te	n. State. Zip Code)			
ID 2 shoul and N 27 is m	<u> </u>	9a. Informant's Name/Relationship (Type, Print)  O.C.M. Thomas J.E. Soul/Brother  19b. Mailing Address (Street and Number of Party Ave. Steward Party P	rtstom,	$PA_{MD}$ 17363 <sub>20</sub>	)1			
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Bo Completed by Eumoral Director		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		City or Town, State			
mor Pages ent of nt: 1f		Tabuna 2 Cremation 3 Removal non State	10-22-200	7 Baltimor	m MD			
Baltin permit. P Departme Importan injury or	t	21. Ign ture of Funeral Service Licens Rould St. de, Director	rzullo.lu	neral Chape	1 P.A.			
	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	or respiratory	Maryland 2	art Approximate Interval			
Physician Medical		ਰਿਮੇlure. List only one cause on each line.		arrost, shook, or free	Between Onset and Death			
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. No Anatomic or Toxicologic Cause or Due to (or as a consequence of):	ı Deatn					
	-	Sequentially list conditions, b						
		if any, leading to immediate Due to (or as a consequence of):						
75. "	a	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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ox 6 th cert	Physician/M	4 Pregnant at time of death 5 Other (Specify)		Į.	Į			
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Vita ysicia direct	P B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nu	rsing Home 5	Residence 6	✔ Other: Scene			
ing Pt		27. Manner of Death  28a. Date of Injury  1 Natural 5 Panding FOUND:  28b. Time of Injury  28c. Injury at Work?  Found:  1 Yes 2 X No.	28d. Descri	be how injury occur	red			
	읡;	2 Accident Investigation 06/12/07 9:30 AM		nown	per or Purol Pouto Number City			
Jivis Ilor A safter I Dire	Certification:	3 Suicide 6 X Could not be determined (Specify) Found: in vacant house	or Town	n, State) 4516 Bartin	per or Rural Route Number, City Mannasota Nore, MD 21213			
y fill		29a. Certifier A Contifuing Physician: To the best of my knowledge, death occurred at the time, date and place		<u> </u>				
the H thin 24 the F the F	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr	ed at the time, d	ate and place, and	due to the cause(s)			
To with To con	ğ.	and manner stated.  29b. Signature and the of certifier 29c. License number		29d. Date sign	ned (Month, Day, Year)			
		O.C.M.E.		June 13, 2	2007			
<u></u>	+	30. Name and address of person who completed cause of death (Item 23a)	04004					
$\mathscr{S}$		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201	<del></del>				
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature						

			1 - For Stata Registrar	State of Maryland		artmen rtificat				Re	g. No2 (	007	34185	
	Physici /Medi		Decedent's Name (First, Middle, La     NANCY FRAN	CES STEWART						2. Date of Death Month Oct	2 Day	2007	3. Time of Death 9:00 a M	
	Examir	ner	4a. Facility Name (If not institution, given Ft. Washington H	ospital			into	Location on the street of the		8. Date of Birth		inty of Death		
	Funeral Director		5. Social Security Number 6. S  031-22-0161  Usual Residence of Decedent	7. Age (In yrs. I	Yrs.	Months Days Hours Min. (Month, Day, Ye				Year) L923	VA	place (State or Foreign ntry)		
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980	be filed within 72 hours after death with the Maryland hat Hygiene. ad other then "naturel", or items 23a or 28e-f show event, the Madicel Examinar must be rodified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2  No ff Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	as or No- etc.)  14. Race - American Indian Black, White, etc.  Specify: Black			
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	od 2 s	F	19a. Informant's Name/Relationship (			ng Address Roan				Route Number.			Code)	
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	Physician /Medical Examiner	er	23a. Part1. Enter the displace, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Secuentially list conditions if any leading to immediate		uence of):		4			dissilation are	ce~>	۷	Approximate Interval Between Onset and Death	
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	quires that an signed b uld be deta	þ	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying c	ause give	en in Part I		23e. Did toba	2-1		he cause of death?	
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0	o To With	2	29b. Signature and title of certifier	Ish m	D		D547	number 723		29	ld. Date si	gned (Month,	O )	
	(3)		30. Name and address of person who Dr. Hengameh N. M	Mesbahi 11711 L	ivings		Road	Ft	. Was	shington	, MD.	20744	<b>,</b>	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	and)									

DHMH 17 Rev 1/2001

**Physician** /Medical **Examiner** the Hospital or Attending Physician; The lew requires that the death certificate be executed

Baltimore, Maryland 21215-0036

the burial-trar physician s been signed b should be deta page 2 s 24 hours after death.

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. There underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delive	ery Day Year
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				24a. Was an autopsy performed 1 Yes 2 ₺₽	prior to co death?	opsy findings available impletion of cause of
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 🖺	R/Outpatient 3		eath <i>(Check only one)</i> Home 5 🗆 Residence	6 □Othor (Speci	60
27. Manner of Death  1  Actual 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ify)	ory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kn iminer: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as s and place, and due	stated. to the cause(s)
29b. Signature and title of certifier	- Am Ja	#	29c. License number	87 <sup>29d.</sup>	Date signed (Month,	Day, Year)

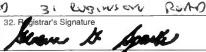
State Registrar

completely within 24

> 31. Date filed (Month, Day, Year) OCT 0 9 2007

STEW ITEN

30. Name and address of person who completed eause of death (tem 23a) (Type, Print)



SEVERINA PERK, MO

2114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** rances Selb. 0850 2007 /Medical give street and number) 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner 10501 300 Westming If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 X F 87 220-18-1629 Director Apr 11, 1920 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a State 10h Count "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Taneytown Director Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21787 1331 Trevanion Road Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white δ 3 ₩ Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Grant Baker Bertha Angel ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Trevanion Road, Taneytown, MD 21787 Bertha Williams, niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State 10/12/2007 Uniontown, MD Church of God Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Situature of Funeral Service Licens 136 E. Baltimore Street, Taneytown, MD 21787 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 neumonia **Physician** 108XS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as signed by the attending the detached for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Congestive 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy performe the Hospital or Attending Physician: "in 24 hours after death, the Funeral Director: After this certifica pletely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 27. Maprier of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 🗖 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

0C

31. Date filed (Mo

30. Name and address v person who com

MISCH

2007

Registrar's Sign

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Carolyn Lucille Steger October 2007 1715 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Feb 10 1925 Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F Director 213-20-9056 82 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at r 28a-f sh notified MD Carroll Westminster 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 410 Dawn Drive 21157 USA Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 □ Divorced natural I Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administration Office City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H f item 27 is marked otl r other traumatic ever 1 and 2 should be Sterling G. Leppo Alice C. Richards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Dawn Drive Westminster, MD Kathryn Turnbaugh/Daughter 21157 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/12/2007 Pages Department of Important: If it any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Embilism munar 4 **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence on Examiner meumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner the death certificate be executed Due to (or as a consequence of): physician and sthe burial-trans resulting in death) Last Box 68760, Physician/Medical 81,8 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HO5 pice 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 139502 43

DHMH 17 Rev 1/2001

State

Registrar

447. East hain street Westminster Mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hosain

OCT 0 9 2007

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31. Date filed (Month, Day, Year)

Syel

MA

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day 9:50 A **Physician** Dorothy L. Stem 2007 October 6 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Months 1 ☐ M 2 🕱 F MD 13 1920 May Director 212-01-8588 Usual Residence of Dec 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Westminster Director Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 Funeral 531 Uniontown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: þ **X**☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Random House Customer Service Rep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Bish Charles Robert Stephan 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 890 Gaming Sq Hampstead, MD 21074 John Stem/son Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Kriders Church Cem 10/10/2007 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Privite Mineral Home and Chapel, P.A. 21. Signature of Funeral Service List 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 / No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 **Z** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 [ Homicide

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760, P.O. | Division or Vital Records, nas After neral Director; A death. within 24 hours a To the Funeral I

r 28a-f show notified at

7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be it

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

of Health a

altimore, Maryland 21215-0036

Certifying Physician: To the best of my knowled Medical Examiner: On the basis of examination curred at the time, date and place, and due to the cause(s) and manner as stated. est of my knowledge 29a, Certifier igation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of/certifier 290. License number

State

death (Item 23a) 30. Name and address person wbe 31. Date filed (Month, Day,

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Registrar

Medical

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State

Registrar

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31. Date filed (Month, Day, Year)

ELKNN, MD - 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department	artment of Health and rtificate of Death	Mental Hygie	ene 3. n. 2007 34191
1	7		Registrar  1. Decedent's Name (First, Middle, Last)	Timodio oi Bodii	2. Date of Death	3. Time of Death
r	Physici /Medic		Kathryn Louise Schmucker		October	Day Year 12, 2007 8:31 P <sup>M</sup>
(a)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
		Н	48127 Peachtree Way	Lexington Park		St. Mary's
П	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthday) 1 □ M 2 ▼ F 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min	(Month, Day, \	
ij.	Director		220–34–3117 69  Usual Residence of Decedent		05/31/19	Washington, DC
	yland now at		10a. State 10b. Counfy 10c. City, Town or Lo	ocation		10d. Inside City Limits
	e Mar a-f sl	ctor	Maryland St. Mary's Lexington	Park		1 □ Yes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country?
	s 23a	eral	48127 Peachtree Way	20653		nited States  14. Race - American Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	rto Rican, etc.)	Black, White, etc.
21215-0036	2 hours atural", cal Ex	ed by	3 M Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dece	edent's Usual Occupation	10	Specify: White 6b. Kind of Business/Industry
215	hin 72 3. <b>an "na</b> Medik	Completed	(Specify only highest grade completed) (Give life.	e kind of work done during most of wo DO NOT use retired)	orking	,
5	yd with	Com	10 Waiti	1		Food Service
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		ume (First, Middle, Ma	•
<u> </u>	Men Men Marken Marken	P	Harvey Theodore Sharrow, Sr.		uise Zidel	
Maryland	d 2 sh th and 7 is n traun			ing Address (Street and Number or F		
	Heali Heali tem 2		Jennifer A. Sullivan/ Daughter   48127	osition (Name of		Park, Maryland 20653 Oc. Location - City or Town, State
ᅙ	ages ent of nt: If i		1 X Burial 2 Cremation 3 Removal from State	matory or other place)	16/2007 T	arrimation Davids MD
altimore,	mit. F partme oortan Injur		) De Games	s Cemetery 10/ 2. Name and Address of Facility Br	10/200/ L	exington Park, MD Funeral Home, P.A.
m	permi Depar Impor any Ir	Ų.	Edward N. Brinsfield, Jr. M00052 22			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as pardia	ac or respiratory arres	Interval Between
	Physician		Immediate Cause (Final disease or condition	Moutaila	ed_	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a onsequence of):	1/ 16 80	ED D	
6,	15 4	-	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	THE THINK!	SILLINE	- 1/121.
	uted Insit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  C.	Demisson S	this	348
oʻ	exectan and rial-tra		resulting in death) Last  C.  Due to (or as a consequence of):	MATA	-	2011
38760,	icate be executed physician and s the burial-transit	dical	d. Caro	nary TWER	11)2	2. 9X
_	ertifica ing ph e as t		IF FEMALE:		¥	1 //
90 100	ath or	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pr pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [	□Ectopic pregnancy	•	23d. Date of delivery  Month Day Year
P.O. Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	1 □ Yes 2 No 9 □ Unknown 4 □ Pregnant at time of death 5 [	Other (specify)		
Œ.	s that med b e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	anderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Records,	equire en sig ould b				1 ☐ Yes	s 2 Mo 3 Probably 4 Unknown
ပ္ပ	iaw re as be 2 sho	Completed	- Challeles		24a. Was an autopsy	
<u>~</u>	The cate h	Son	1		perform	ed? death? ☑No 1 ☐ Yes 2 ☐ No
Vital	<b>nysician</b> : The law nis certificate has I I director, page 2 s	Be	25. Was case referred to medical examiner?		eath (Check only one	
ō	Phys this al dir	P.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiel  27. Manner of Death 28a. Date of Injury 28b. Time of		Home 5 Residen	nce 6 Other (Specify)
on	ding Ph h. After th funeral	tion	1 Manatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	Zod. Describe nov	rinjury occurred
Division or	Attending Physician: r death. ector; After this certifics by the funeral director; R	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st		28f. Location (Stre	eet and Number or Rural Route Number,
ă	s after s after s all Direction bed in b	Serti	4 Homicide determined building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical (	29a. Certifier (Check only one)  1   Certifying Physician: To the best of my knowledge, deat 2   Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
	^ ^	2.452.75	h wat but M	1 DOGLH	9	18-14-157
1	Mr )		30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)	-	10 10 01
1	40			otch Road, Hollyw	ood, Mary	land 20636
R	Sta Registr		31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	book		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Marie DeBala Strickland October | 18. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 23195 Barley Court Lexington Park St. Mary's 9. Birthplace (State or Foreign Country)
Minnesota 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 88 February 14,1919 Director 144-03-7789 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director St. Marv's Lexington Park Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23195 Barley Court 20653 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) U.S. Government Administrative Assistant 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Seigal Stephen DeBala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and important: if item 27 is n any injury or other traum 17078 NW 22nd Street, Pennbrooke Pines, Florida 33028 Bela Rezman / Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) National Memorial Park 20, 2007 Falls Church, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, F.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (ERESTO VASCULAR Physician /Medical Due to (or as a consequence of): Examiner ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the. as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s 24a Was an certificate 1 Yes 2 1√10 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Hospitai or Attending 1 Natural the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D37096 10-18-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJBINDER S-G-LL SHA SHAM ASSUCIATES HUZLYWOOD MI) 26836 31. Date filed (Month, Day, Year) 32. Rg trar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** VERIA 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Pacility Name (If not institution, give street and number) Examiner Lenter NICOMICO alesburu ledica If Under 1 Year | If Under 2 Hrs.
Months | Davs | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 □ M 2 □ KF Months Days 213-14-171 93 Director 28 ARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Salisbury M) Avey/Awd Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code LRSA 2/80 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: BLACK Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DomEstic +2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PRRIE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLEBURY Brown ALECA NAYLOR NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location Lity or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State SIANI 10-13-07 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SEWAR SALES. Mol HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DSCLEILOTI Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: ed by the attendin detached for use If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month 5 Other (specify) 2 DNO 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by EUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably FIBRILLATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: Certification: To Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 27. Mann of Death Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Year)

(Month, Day,

se of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ROBERI SAMES hockley 2007 october /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City/Town, or Location of Death Examiner Medica Regions. meco 5. Social Security Number 1 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Min **M** 2□ F 220-26-7914 Director 12-31-1933 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show death with the Marylar other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Wicomilo MARYLAND SALISBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21804 USA ZiON ROAD 30465 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces: 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1955 - 85 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ∏Yes Z⊠No Specify: Completed by 3 Widowed 4 Divorced Black 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than Military NONE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shockley PARKER ElizAbeth LAURA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trausonce. Shockley HRUELLA Salisbury Rd, , md ZON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) pring fill HEDROW, MARYLAND GARDENS -12-0 D 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SEWAR Salis. Mad 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the cause of the death. Immediate Cause (Final disease or condition resulting in death) Physician rewmonia /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Stridium Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy perform Hospital or Attending Physician: funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) AVITA

State Registrar 100E, Cemil St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMLET

TB,M.D.

32. Registrar's Signature

TEVEN

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registra

Severna Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 5 2007

31 Robinson Road

32. Resistrar's Signature

Dr. Elaine Arata

31. Date filed (Month, Day, Year)

Vital the Hospital or Attending Physician: Division of To the Funeral

23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 1 🗸 Yes 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 1 Yes 2 No Pending 10/19/2007 11:15 am subject fell from ladder 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State)
546 Centre St. Cumberland, MD determined (Specify) outside building 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Death

29d. Date signed (Month, Day, Year)

October 21, 2007

Registrar DHMH 17 Rev 1/2001

Certification:

Medical

State

29b. Signature and title of certifier

Patricia Aronica-Pollak MD.

31. Date filed (Manth, Pay Year) 2007

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32, Registrar's Signature

07-08167 Mark G. Schafer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3419 2007 1- For State Certificate of Death Reg. No Mark Gregory Shafer 2. Date of Death 1. Decedent's Name (First, Middle, Last Physician/ Month Day October 20, 2007 Mark Gregory Shafer 0728 hrs **Medical Examiner** Mark C. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Frederick 5622 Boone Avenue Frederick 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland Min 216-70-0644 51 Months Days Hours 06-14-1956 Director 1X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County loc. City, Town or Location Frederick Frederick Maryland 1 X Yes 2 No 23a or 28a-f show notified at once. the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21704 United States 5622 Boone Avenue death with Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces' 2X No Yes White 1 Yes 2 X No specify: Divorced If Yes, Give Yee Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 Panet of Health and Mental Hygiene.

ant: If item 27 is marked other than "n
or other traumatic event, the Medical E College (1-4 or 5+) Construction Carpenter 18.Mother's Name (First, Middle, Maiden Surname)
Barbara Hillery 17. Father's Name (First, Middle, Last)
Julian A. Shafer Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9823 Gordon Court, Walkersville, Maryland 21793 ٥ 19a Informant's Name/Relationship (Type, Print ) Scott M. Shafer / Brother Important: If item injury or other trav October 22, 2007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, 1 Burial 2 K Cremation 3 Removal from State crematory or other place) Smithsburg, Maryland Smithsburg Crematory Donation 5 Other Specify Z2. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, 21. Signature of Funeral Service Licensee M01433 MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Narcotic (morphine) and oxycodone intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED #1 perME g874 #1.23a.27.28a-f. pe X UNPENDED physician the burial -IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the for use as the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 V Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of Injury Certification: Natural Yes 2 X No Director: unk Pending Fnd 10/20/2007 Fnd 7:00 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 6 X Could not be Suicide or Town, State) determined residence To the Funeral Boone Ave. Frederick, MD Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 🗸 and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. October 21, 2007 me and address of person who completed cares of death (Item 23a

State Registrar

Thepdore M. King, Jr., MD.

24

2007

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 3. Registrar's Signature

**ORIGINAL** 

111 Penn Street, Baltimpre, MD 21201

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07-08162 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Eugene Turner 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 19, 2007 2000 hrs EUGENE GLENN TURNER Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore City 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Country) Months Days Hours Min Director 219-46-4363 58 Oct 22 1948 1 X M 2 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits iny 10b. County 1 Yes 2 X No MD Kent Galena or 28a-f show items 23a or 28a-f shoust to be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If them 27 is match other than "natural", or items 23a or 28a-f sho
njury or other traumatie event, the Medical Examiner must be notified at once. Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 31395 Jim Davis Rd. 21635 U.S.A. Funeral 14 Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Armed Forces? 1 Never Married 1 X Yes White 1968 Yes, Give Year Yes 2 X No specify Specify: Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manufacturer Assembly Line Worker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph W. Turner Hester Amanda Ford Be 19a. Informant's Name/Relationship (Type, Print) (wife) 31395 Jim Davis Rd. Galena, MD. Patricia Turner 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State 10/26/07 Galena, MD. Galena Cemetery enation 5 Other Specify 2. Name and Address alena Fi 18 West of Foneral Se of Stepl Stephen ena, MD uneral Cross Home St. M00510 23a. Den I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Chest Injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical physician a the burial -X AMENDED UNPENDED Iten#28a,perME,C872,10/25/07,WS 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day the attending Fetal death detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Completed icate has been si page 2 should b 24a, Was an autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Inpatient 1 V Yes ٩ 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? FOUND Day Ya Pinned under tractor 1 FOUND: Natural Yes 2 V No Pending 1912 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State L<sub>21635</sub>Schaec Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, find or Attending Physician: The law requires that the death certificate be Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of No Hospital or Attending Physician: Ti 4 hours after death. Funeral Director: After this certifica ely filled in by the funeral director, pa Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 32885 Galena Sassafrass Road, Galena, MD determined (Specify) Ditch To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. October 20, 2007 lot 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year 32 Registrar's Signature State 2007 4 Registra **ORIGINAL** DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 4, 2007 Year **Physician** Taylor 6:00 Dwight Ам Ronald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hosp. Ctr. Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9-22-40) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1₩ M 2□ F 67 577-54-4760 D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1y⊒Yes 2 □ No Director MD Prince George's Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20613 11906 Lusby's Lane U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status African-American 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kirid of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clergyman Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Harriet L. Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11906 Lusby's Ln, Brandywine, MD 20613 Ruth Taylor-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 10-12-07 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cem. Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Fu Home 2504 28th St., N.E., WDC 20018 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CORONARY SYMBRUME **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ MEM OHSET SEIZHRE 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed?
Yes 2 No il or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2□ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR (20)

State Registrar SMHC.

31. Date filed (Month, Day, Year)

OCT 1 0 2007

7503

32. Registrar's Signature

SURRATTS RUAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILE MAHAJAN IND

150685

10/04/2007.

CR P

State Registrar

OCT 1 2 2007

livado

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day October 4, 2007 Betty Lou Thacker 2:00 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Days Months 1 □ M 2 🗓 💥 83 20, 1924 Maryland 579-22-6384 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County XXXX 2 No Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Severn Ave. Apt 602 21401 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2/CXNo Specify White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph D. Tarr Emma Louise Jefferson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lori Q. Rose / Friend 907 Mastline Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 10/8/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Micho 147 Duke of Gloucester ST. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asystolic Cardiac 2 hours disease or condition resulting in death) Du (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

the death certificate be executed use as the burial-tran and Box 68760, attending physician for use as the buria P.O. cate has been signed by the page 2 should be detached Division or Vital Records, certificate has this

Examiner Physician/Medical à Completed funeral director, Certification: To After spital or Attendi nours after death. Ineral Director: A y filled in by the fu

Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

Completed by

Be

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Item 27 Is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after a and Mental Hygiene.

Is marked other than "natural", or Itel

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

Diabetes.		1 ☐ Yes	2 No 3 Probably 4 Unknown		
Hypertension	1			24a. Was an autopsy performed?	
25. Was case referred t edical examiner? 1 ☐ Yes 2☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 ☐ □	Othor	eath (Check only one)  Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specification)	ome, farm, street, factory)	ry, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ysician: To the best of my kno niner: On the basis of examina and manner stated.				s) and manner as stated. nd place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

Parkeway, Annapolis Mary and 21401

2002, Medical

State Registrar

within 24 hours an Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 15, 2007 3:30 June Tedrow October 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 □ M 2 🔀 F Months Hours Director 06/15/1909 040-46-0102 <u>Pennsylvania</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Pennsyl-1 ☐ Yes 2 XNo Director Stoystown Somerset vania 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 251 Tedrow Road 15563 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin Zimmerman Florence Muller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline D'Wynter/Daughter P.O. Box 309 Avenue, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 10/16/2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequi-Physician/Medical Examiner ce of) or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physiciar IF FFMALE . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) should be detached 9☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No page 2 1□ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Discontinuous Communication and/or investigation in my entire transfer death and the cause(s) and manner as stated Discontinuous Communication and Communication 29a. Certifier Medical сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address

DHMH 17 Rev 1/2001

State

Registrar

James P

31. Date filed (Mont)

drboe,

1 7 200?

M.D

24035 Three Notch Road, Hollywood, Maryland

20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylar		artmen rtificate			and M	lental Hy	gien Reg. N		7	34203
1	Physici		1. Decedent's Name (First, Middle, Last)  Lydia R. Thompson								2. Date of Do	eath	¥ 20	O 7	3. Time of Death 11:33 P M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death	ОСТОВ		. County		11:33 P M
			115 Allnut Court				Princ					C	alve:		
	Funeral Director		3/9-20-03/3	7. Age	94	last birthday) Yrs.	If Under Months	Days	If Under		8. Date of Bi 12/20/	1912	)	9. Birthp Coun Mary	plece (State or Foreign ntry) 'Land
	yland Now		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Limits
	Ba-fst	Director	Maryland Calvert		Pri	nce Fre	derio	ck							1 ☐ Yes 2 No
	with the a or 2	Dire	10e. Street and Number 115 Allnut Court #6	503			10f. Zip	_				10g. Citizen of What C United Sta			
	death ms 23	Funerai		12. Was Decedent 8	ver in U	.S. 13. \	20678  Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I			ecify Yes or No		14. Race	e - Americ	an Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I're Medical Examinal must be reciliad at once.	b	1 ☐ Never Married 2 ☐ Married 3 ∰Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 X N If Yes, Give Year or Dates:	0	1	fYes,spec 1□Yes 2		Specify:	Puerto	Rican, etc.)		Blac Specify	Black, White, etc.	
Maryland 21215-0036	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Deced	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)				16b. H	(ind of Bu	siness/Inc		
121	within lene. than he Me	ompi	Elementary/Secondary (0-12)	College (1-4or 5	+)	Homen		e retired)				,	lome		
d	e filed al Hygi other vent, I	Be	17. Father's Name (First, Middle, Last)			Homen	akcı		18. Mothe	r's Name	(First, Middle	-		е)	
<u>ylaı</u>	should band Ments marked	To	William Brown						Rosa						
Mar	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship (Ty)  Jean M. Thompson/I	,							Route Numb				
ē,	is 1 and 3 Health item 27 other tra		20a. Method of Disposition		20b. P	Place of Disposemetery, cren				_	ate PITICE			City or To	MD 20678 wn, State
altimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		las Cre	mator	·v	10						aryland
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility George P. K 2973 Solomons Island Rd., Ed									Kala Edgev	as Fu vater	nera , MD	1 Home 21037
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin Due to (or as a		Den	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
50,	cate be executed physician and ithe burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying that fulfacted events resulting in death) Last	Due to (or as a	·										
P.O. Box 68760	= 70 2		in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal ime of de	Ideath 3 = eath 5 =	Ectopic pre Other (spe	cify)					23d. Date Mon	e of delive	ry Day Year
	w requires th been signed should be de	þ	Part II. Other significant conditions con	tributing to death bu	t not resu	ulting in the un	derlying ca	use giver	n in Part I.			obacco i Yes 2			e cause of death? ably 4 Dunknown
al Records,		Completed									24a. Was autor perfo 1 \( \text{Yes} \)		pi de	rior to comeath?	osy findings available apletion of cause of
Vital	Physician: this certific	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 🗆	ER/Outpatient	3□ 00/	0.4			<i>(Check only o</i> ne 5≯Fesion		c = 0++-	. (0	
Division of	ding Ph After th funeral	ation: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury		c. Injury		2	8d. Describe				)
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At ho (Specify	me, farm, stre	et, factory,	office	- 2017-	2	8f. Location (S City or Tox	Street an vn, State	d Numbe )	or Or Rural	Route Number,
	To the Hospi within 24 hour To the Funer completely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examin	cian: To the best of er: On the basis of a and manner stat	xamınat	wledge, death ion and/or invi	occurred a estigation, i	t the time in my opi	, date and nion, death	place, a	nd due to the	cause(s) date and	and man place, a	ner as sta nd due to	ated. the cause(s)
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	Mea	)	20 Name and all the second	3/mm	V 2	20.1		t) 1	,7 n3	6		/	0/4	190	07
	10		30. Name and address of person who con	3 J Sprv	se	23a) (Type, P	Pint)	rah	Die	ع	Chest	er, u	MI)	216	19
4	Stat Registra		31. Date filed (Month, Day, Year)  OCT 0 9 2007	Some Stran	's Signat	L A	N/L								6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Truit 0. 2007 October Jean 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury pastal Hospice Wicomico at the If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🗓 F 3-29-1927 218-20-4504 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Brewington Drive 21801 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ∏Yes 2∏ No fYes, Give ∕ear or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) H. Winter Owens Wilsie Lowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald B. Truitt, Jr. - Husband 315 Brewington Drive, Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Specify) 10-10-2007 Delmar, Delaware Creamtory of Delmarva 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only are cause on each line. Immediate Cause (Final Mekstatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21/No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No. 24a. Was an autopsy performed es 2/2 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a State

MD

Director

Funeral

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Completed

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Il Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other:

5

injury o

'n

Baltimore, Maryland 21215-0036

burial-transi as

P.O. Box 68760.

Division or Vital Records,

Examiner

pue attending physician for use as the buria ed by the a detached for peen

death certificate be executed Physician/Medical Completed To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: Be P Certification:

1 ☐ Yes 2 No

27. Manner of Peath

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Medical

State Registrar

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

10 BOX 1733

2 ER/Outpatient 3 DOA

28b. Time of

Injury

29b. Signature and title of certifier

Inpatient

(Month, Day Year)

28a. Date of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coastal 31. Date filed (Month, Day,

5 ☐ Pending investigation

Year) 32. Registrar's Signature 1 0 2007 OCT

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year JO ANN VENT 10 06 2007 0910 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CUMBERLAND ALLEGANY WMHS-BRADDOCK CAMPUS 3irthplac Country) PA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 21X F 59 1948 211-38-7098 12 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 □ No GARRETT GRANTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 185 RAVINE ST. 21536 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 12 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH HOLT MARTHA BEGGS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS VENT / SPOUSE P.O. BOX 536, GRANTSVILLE, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ADDISON CEMETERY 10/09/2007 4 Donation 5 Dother (Specify) ADDISON, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility // CC0376 HUMBERT FUNERAL HOME, PO BOX 37, CONFLUENCE, PA rice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MESOTHELIOMA unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

be executed burial-tran and P.O. Box 68760, attending physician as the t for use ed by the a signed t Records, cate has been signated bage 2 should b Division or Vital

Physician:

this

**Physician** 

/Medical

Examiner

Examine Physician/Medical <u>۾</u> Completed Be P To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral funeral

**Physician** 

/Medical

Director

Funeral

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Completed

Be

2

MD

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he matified at

altimore, Maryland 21215-0036

Certification:

Medical

1 Yes 27. Manner of Death

5 Pending investigation Ž ☐ Accident 3 ☐ Suicide determined 4 Homicide

6 Could not be

Date of Injury (Month, Day Year) 28b. Time of Injury

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

900 SETON DR. CUMBERLAND

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Ankan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. ATYER 31. Date filed (Month, Day, Year) State

29a. Certifier

OCT 2 3 2007

2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 18 **Physician** 2007 9:35 P Esther Willard October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 01-03-1912 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 TF 217-18-7889 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 East 6th Street 21701 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.
The street of Health and West Hyglene.
The marked other than "natural", or thems 23a.
The other traumatic event, the Medical Examiner must Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔼 No White Specify Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Şecondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Edgar Willard Susan Elizabeth Myers ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 B Stratford Way, Frederick, Maryland 21701 Regina Roberts / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or oti October 22, 2007 1 N Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Reeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 2170. M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 **Physician** leyral Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Days. neumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physiclan Physician/Medical as the IF FEMALE: asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the at d be detached for 5 Other (specify) I Yes 2 No 9☐Unknown 9 ☐ Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed After this certificate 1 Yes 2 No or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fur M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 10-19-07

Registrar

DHMH 17 Rev 1/2001

State

TOLL

House Ave Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32 Registrar's Signature

Coulds

31. Date filed (Month, Day, Year)

OCT 2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#26, per PHYS., G872, 10/24/0/, WS
State of Maryland Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Jonathan Earl Ward September 7, /Medical 2007 12:25 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7739 Greenbrook Drive Greenbelt Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 237-13-2257 1√2 M 2□ F Months Days Hours Min. 45 Yrs. Director March 7, 1962 Hampton, VA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location or Itams 23a or 28a-f ehow 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Maryland Prince George's Funeral Director 1y Yes 2 □ No Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7739 Greenbrook Drive 20770 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Novorced Specify: Black "natural", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Private permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any fluiry or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luke McCoy Ward, Sr. Florence Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline W. Ellis 1349 Kennedy St., NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 △Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Willow Church Cemetery Sep. 14, 2007 Rich Square, NC 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Immediate Cause (Final disease or condition resulting in death) Breinous Physician /Medical Due to (or as a consequence of): Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2000 certificate has been si rector, page 2 should Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1 ☐ Yes 2 € No. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence ther (Specify) 1 ☐ Yes 2 2 100 ٩ this: After the 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide within 24 hours after of To the Funeral Direct completely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 3 FYAN MAP 1/ 701 LILINGEDON 34. Date filed (Month Dag Yaar) 2007 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Пау Month **Physician** Year Judith Ε. 2007 Wiley October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges

9. Birthplace (State or Foreign Country) Southern Maryland Hospital Clinton
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 🖫 F 220-17-5786 Director Sept.26,1954 Trindad Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County "natural" or Items 23a or 28a-f show dical Examiner must be notified at 1 ¥Yes 2 □ No Director Md. PG Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4408 Brinkley Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "rany lijury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Veterinarian Technician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard St. Hill Frederica Isaacc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 Brinkley Road
Temple Hills, Md.

20b. Place of Disposition (Name of cemetery, crematory or other place) Frank Wiley/husband 20748 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/15/07 Andrews Cem. Couva, Trinidad 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End to Cervi La

Due to (or as a consequence of): **Physician** Caram with /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 Month in the past 12 months? Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐No ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an pate has t autopsy performed' certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10.8.07 17.0 Rute Pan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20962 Georgia Ave Suit J-41 Silver Sp. FARAHIFAR 1-0 9801

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar

32. Registrar's Signature

*			For State	State of Maryla		artment of rtificate of			•			
			Registrar  1. Decedent's Name (First, Middle, Later)	et)		i liiicale Ui	Dealii	2. Date of De	Reg. No.	200	34209	7
	Physici		Myrtle	Louise	Whit	e		October	Day	Year	7:12 P M	
2	/Medi Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Death		-	County of Dea		_
			St. Mary's Hospital			Leonard	ltown			St. Mary	s	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In)	yrs. last birthday, Yrs.	If Under 1 Yea Months Days		July 0,		9. Bir	thplace (State or Foreign	
	Director		Usual Residence of Decedent	33	TIS.			oury o,	1712		meetiede	_
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation	_				10d. Inside City Limits	_
	e Mary 3a-f sh tified	ctor	Maryland Prince Geo	rge's	Distri	t Heights					1 □ Yes 2 □No	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 6527 Halleck Stree	t		10f. Zip Code	0747		10g. Citi USA	izen of What Co	ountry?	
	r dea	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ıban, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, Whit		
21215-0036	ours afte rai", or if Exa <u>min</u>	by	1 Never Married 2 Married  Widowed 4 Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 □ Yes 2 🖾 No				Specify:	White	
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lan'	should be fand Mental Band Mental Band Mental Bandarked of	To B	Henry Joseph	Goebel			Myrtle	Lillia	an	Miller		
Maryland	2 shou and A Is mai		19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Stree	et and Number or Ru	ıral Route Numbe	er, Cify c	or Town, State,	Zip Code)	_
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Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr		20a. Method of Disposition  1 V Urial 2 Cremation 3		<ul> <li>b. Place of Disposemetery, cre</li> </ul>	osition (Name of matory or other p		Date	20c. Lo	ocation - City or	Town, State	
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Ba	permit. Pages 1 Department of H Important: if ite any Injury or ot once,		21. Signature of Funeral Service Licer	o A			ress of Facility Ge Hill Road O				lame PA 1745	
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				Thaveri-			32651		10	10/20	07.	
R	-(8)		30. Name and address of person who Rita B. Jhaveri, M.D.		, , ,,		Park, Md. 2	20653				

31. Date filed (Month, Day, Year)

OCT 1 1 2007 State Registrar

32. Registrar's Signature

			For State Registrar	State o	of Maryla		artment of H		•	giene Reg. No.?	07	31,210
	E 43		1. Decedent's Name (First, Midd	le, Last)					2. Date of De	eath Day	Year	3. Time of Death
55;	Physici /Medic		ANNIE	LAURA	W	HITE			OCTOBER	5 200	07	8:55 P M
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A STATE OF THE PARTY OF THE PAR	Funeral Director		5. Social Security Number 579–46–0932	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	lrs. 8. Date of Bi (Month, Di JUNE 4	1934	9. Birthp Cour VIR(	place (State or Foreign htry) GINIA
	and ww		Usual Residence of Decedent  10a. State 10b. County	/	10c. (	City, Town or Lo	cation				1	10d. Inside City Limits
	Maryl -f sho	į	MD PRINC	E GEORGE"	S	LANDOVE	R					1∭Yes 2□No
	th the or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?
	23a c	ra	2206 VERMONT	AVENUE			2078			U.S.		Indian
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21215-0036	72 hou natura lical E	Completed	15. Decede	nt's Education est grade completed	)	16a. Dece	dent's Usual Occup	ation during most of	working	16b. Kind of B	lusiness/In	dustry
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121	Hygie Hygie ther t	S	8th 17. Father's Name (First, Middle	, Last)		п	OME MAKER		Name (First, Middle			
lan	ental ked o	To Be	CHARLES WHITE					NANCY	Y BRACIE			
Maryland	nd 2 should be filed within atth and Mental Hygiene. 27 is marked other than " r traumatic event, the Mec		19a. Informant's Name/Relation DENISE BUSH / I			19b. Maili 2002	ng Address <i>(Street</i> E. MARLE	and Number or BORO PIE	Rural Route Num KE # 104	ber, City or Town LANDOVEI	, State, Zip R <b>,</b> MA	p Code) RYLAND 2078
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		n State		osition (Name of matory or other place CEMETERY		Date -13-2007	20c. Location	-	
Balti	permit, I Departm Importar any inju		21. Signature of Funeral Servic		,		2. Name and Addre	,	J. B. JE AD LANDOV			
R	9.5.		23a. Part1. Enter the disease shock, or heart failure.	or complications that	caused the de	eath. Do not en	ter the mode of dyin	ng, such as care	diac or respiratory	arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a cons	sequence of	Fail	rie				
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O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live	utcome pf pre birth 2   F gnant at time ( nown	etal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у			ate of deliv	very Day Year
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on (	ding I	tlon:	1 Natural 5 ☐ Pend		onth, Day Year	r) Injury	Wo	rk? ]Yes 2∐No	200. 0030115	Thew injury door	1100	
Division	I or Attending after death. I Director: Afte	Certification:	3 Suicide 6 Coul	d and her	ce of injury - A Iding, etc. (Sp	At home, farm, si ecify)	reet, factory, office		28f. Location City or T	(Street and Num own, State)	nber or Ru	ral Route Number,
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certify (Check only 2 Medicone)	ring Physician: To t al Examîner: On the and ma	he best of my basis of exan anner stated.	knowledge, dea nination and/or i	th occurred at the t nvestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time	e cause(s) and n	manner as e, and due	stated. to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certing	ier LULL			29c. Licen:	599°	81	29d. Date sign		-
K	(2)		30. Name and address of person MUKEMIL AB	DELLA MD	3001	Hospita:	Print) L Drive C	heverly	, Maryla:	nd 20795		
	St Regist	ate trar	31. Date filed (Month, Day, Yea OCT 1 1 2007	Lieuw 32.	Registrar's S	ign ture			_			

DHMH 17 Rev 1/2001

7-07825 ndrew Mark Whitte		f Health and Mental Hygiene	egible. 2007 3421
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of D	Day Year OCEE has
" "cal Examiner	Andrew Mark Whittenburg  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	r 7, 2007 U000 NTS
	1 Truxton Park	Annapolis	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 13-76-6085 1 M 2 F 34 Yr	Mantha Dava Haura Min	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
ıny	Usual Residence of Decedent  10a. State	tion	10d. Inside City Limits
show and one.	Maryland Anne Arundel Annapo	olis	1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Important: If item 27 is marked other than "healtral Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 113 Merryman Court	10f. Zip Code 21401	10g. Citizen of What Country?  USA
ms 23a be not	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
r death with or items 23 cmust be no	1 Yes 2 X No	Yes 2 No specify:	Specify: White
urs afte	or Dates:	ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 state within 72 hours tygiene. other than "natur the Medical Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Teacher	Music
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	12th Plane 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	1
21215 build be filee Mental Hy marked o ic event, th	Paul Alan Whittenburg	Gladys Pag	
nore, MD 21215-0036 sages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. ut: If Item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by I		ng Address (Street and Number or Rural Route L Fairfax Rd., Annapol	
e, MD and 2 sho Health and item 27 is traumati	20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery, Date	20c. Location - City or Town, State
imore Pages 1 ment of E	Burial 2 X Cremation 3 Removal from State crematory or a large A Donation 5 Other Specify: Kalas Cre		Edgewater, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21. Signa of Funeral Service Linsee 22.	Name and Address of Facility George	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	973 Solomons Island Rd the mode of dying, such as cardiac or respirator	
'Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Contact Gunshot Wound of Head		Death
_xammer	or condition resulting in death)  Due to (or as a consequence of):		
196	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ted nisit Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
executed in and all - transit			
i760, ficate be exe g physician the burial -	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transical Contributed by Divisional Medical Expedical Contributed by Divisional Contributed by Divisional Medical Expedical Contributed by Divisional Medical Expedical Contributed by Divisional Contribut	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
b. Bo the dea	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
P.O. B res that the d signed by the be detached by the by Dr.			Yes 2 No 3 Probably 4 Unknown
Records, I The law requires ficate has been significate by page 2 should be completed.			Was an autopsy findings available prior to completion of cause of
Recc The lav			performed? Yes 2 No 1 Yes 2 No
of Vital Recoling Physician: The law After this certificate has 'uneral director, page 2 sl	25. Was case referred to medical examiner?	26.Place of Death (Check only one) ent 3 DOA Other Wursing Home	5 Residence 6 ✔ Other: Scene
of Vi g Physi frer this neral dir	27 Manner of Death 28a Date of Injury 28b Time of	of Injury 28c. Injury at Work? 28d. Desc	cribe how injury occurred shot self
ion tendin leath. A the fur	1 Natural 5 Pending FOUND: POUND: Accident Investigation Oct 7, 2007 FOUND:	1 Yes 2 No	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted after the contributed by the funeral Completed by the fu	3 Suicide 6 Could not be determined (Specify) Park/Recreation Are	_ or To	tion (Street and Number or Rural Route Number, City own, State) n Park, Annapolis, MD
To the Hospi within 24 hou To the Funet completely fi		curred at the time, date and place, and due to the gation, in my opinion, death occurred at the time,	e cause(s) and manner as stated. date and place, and due to the cause(s)
To T	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
200	- Chul	O.C.M.E.	October 7, 2007
1000	30. Name and address of person who completed cause of death (Item 23a)  David Fowler M.D. Chief Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
Stat	e 31. Date filed (Month, Day, Year) 32. Bigistrar's Signature		
Registra		IAI	
DHMH 17 Rev 1/200 OCME 2006	OCME ORIGIN	I/AL	

DHMH 17 Rev 1/2001 OCME 2006

within 24 hours a Medical

31. Date filed (Mo State Registrar

4 Homicide

29b. Signature and title of certifier

John W. Roache, M.D.

29a. Certifier

28130 Three Notch Road, Mechanicsville, Maryland 20659 egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my entire death occurred.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

15027

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 10 Physician  $\mathbf{A}^{\mathsf{M}}$ October Clarence William . Warner 2007 3:57 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick 9. Birthplace (State or Foreign Country) Maryland f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Apr. 11, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1<del>√</del> M 2□ F Months Days Hours 98 214-28-0368 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21788 11122 Angleberger Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify: þ White 3₺Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Fisher Ernest Warner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11122 Angleberger Road, Thurmont, Maryland 21788 Mary Frances Bostian/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 10/13/07 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Sign ture of Fundral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part T. Enter the disease, or complications that caus. The leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumania /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coronany Arteny 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has b irector, page 2 sl autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 32 1No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

thin 24 hours after death.

the Funeral Director: Af
mpletely filled in by the fur within 24

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Shah

Johnson Dr. ( homas

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0060417

29d. Date signed (Month, Day, Year)

Frederick MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician October 8, 2007 4:30 P M Wilbur Wantz, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8 West Moser Road Thurmont Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | May | 10°, 1930 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Mary Land 1 X M 2 □ F 77 218-24-9064 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be norified to once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Maryland Frederick Director Thurmont 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 West Moser Road 21788 United States Funeral Race - Americen Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 □ No
If Yes, Give
Year or Dates: 1951–53 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No White Specify Completed by 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Plasterer** Construction 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be John. Russe11 Wantz Henrietta Bauer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13171 Mentzer Gap Rd./ Waynesboro, PA 17268 Donna Wantz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Creagerstown Cem. 10/12/2007 Creagerstown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, Maryland 21702 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co of quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending f IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an eutopsy performed? certificate 2, To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: Injury 1 Latural 5 Pending To the Hosping.

Within 24 hours after death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

South Washington

30. Name and address of person who completed calse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 0CT 1 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. ZUU7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 6 2007 ear 5:00 p.M Joe Ann Wood 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Golden Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🙀 F 220-28-6804 75 Maryland Dec 25, 1931 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County Frederick Clarksburg Maryland 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 20871 10e. Street and Number 14449 Lewisdale Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2 | No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora E. Nicholson Sterling Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1716 Harpers Ferry Road, Knoxville, Maryland Bonnie Moore- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Hyattstown Methodist 10-13-2007 Hyattstown, Church Cemetery Stauffer Funeral Home Hyattstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more or any injury or other traumatic event, the Medical Examinar more or 28a-f show once.

sician and burial-tran

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

	Tharon Camel	le Collène	1621 Ope	ossumtown P	ike, Frede	rick, Ma	ryland 21	70
1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do rone cause on each line.	not enter the mode of	f dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	Kidhe	y canc	ev			
		b		100				
2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):					
Lvail	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	of):					
		d						_
y sicial William	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ ₩6  9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ⊟Ectopic preg 5 ⊟ Other (spec			23d. Date of de Month	livery Day Year	
n Dy L	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cau	se given in Part I.	23e. Did tobacc		o the cause of death? robably 4 ∐Unkno	
ombieno.					24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause	ble of
0	25. Was case referred to medical			26. Place of De	ath (Check only one)			
2	examiner? 1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Ou	·	Other: Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)	
micanon.	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Time of 28d njury M	. Injury at Work? 1∐Yes 2 □ No	28d. Describe how it	njury occurred		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)	and Number or R ate)	ural Route Number,				
Olcal C	29a. Certifier (Check only one)	ysician: To the best of my knowledge niner: On the basis of examination ar and manner stated.	e, death occurred at nd/or investigation, in	the time, date and place my opinion, death occ	e, and due to the causeurred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)	
1	20h Signature and title of certifier		29c. l	icense number	29d.	Date signed (Mon	th. Dav. Year)	

Registrar DHMH 17 Rev 1/2001

State

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Johnson Dr. Frederica MB 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 1 1 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 5 Day **Physician** 2007 6:50 P M Paul T Wilhide /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 2, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 83 Maryland 219-12-2260 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a∙f show the Medical Examiner must be notified at Walkersville 1 ☐ Yes 🌠 No Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21793 8703 Antietam Drive USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 AYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🗌 No White 1 ☐ Yes ANO Specify. Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Company 12 General Manager artment of Health and Mental Hygortant: If item 27 is marked othe Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Long Ernest C. Wilhide, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8703 Antietam Drive, Walkersville, Maryland 21793 Laura Wilhide - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or Resthaven Memorial 10-10-2007 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature | Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 amille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ~ 4 DAYS ACUTE INFFRIOR MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical the for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown REMAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autonsy perform certificate 1□ Yes 2□ No Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) s after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 1 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Maryland 21215-0036

altimore,

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State OCT 1 1 2007 Registrar

29b. Signature and title of certific

RICURD L. GOVEH

29a. Certifier

Medical

WALKERSVILLE MD 21793 POB 300 328 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

32171

29d. Date signed (Month, Day, Year) 10/6/07

			For	State of Marylar				Mental Hyg	iene	7 01017
			1 State Registrar  1. Decedent's Name (First, Middle, La	astl	Cer	tificate of	Death	2. Date of Dea	eg. NoZ U U	3. Time of Death
	Physici /Medio		Johnnie	Winder				Month		ear AM
1	Examir		4a. Facility Name (If not institution, gir	_		4b. City, Town,	or Location of Dea	th	4c. County of	
	Funeral Director		5. Social Security Number 6.	Sing + Rehab Sex 7. Age (In yrs.	. last birthday) _ Yrs.	If Under 1 Year Months Days			Wicoui	B. Birthplace (State or Foreign Country)
	D .		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	ation		6 26.		10d. Inside City Limits
	the Maryl 28a-f sho	ector	Md Soners	FOL E	den				0- 00	1 Tes 2 No
	s 23a or	Funeral Director	14579 Saw	dy Lave		10f. Zip Code	22		og. Citizen of Wh	.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, I're Medical Examinar must be notified at once.	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in the Armed Forces?  1 XYes 2 No 196 If Yes, Give Year or Dates: 191	71 "	/as Decedent of I Yes, specify Cub ☐ Yes 2 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
2-00	72 hou		15. Decedent's E (Specify only highest gr	Education	16a. Deced	ent's Usual Occu	during most of wi	orking	16b. Kind of Busi	ness/industry
21215-0036	d within giene. or than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	CUS	to dia	) () () () () () () () () () () () () ()		1)1-41	High School
	ould be filed Mental Hygi arked other atic event, II	To Be (	17. Father's Name First, Middle, Last	idalah lalia	uda-		18. Mother's Na	arne (First, Middle,	Maiden Surname)	7
Maryland	nd 2 should alth and Mer 27 is marks ir treumatic		19a. Informant's Name/Relationship	(Type, Int)	19b. Mailing	Address (Street	and Number or F	iural Route Number	City or Town, St	ate, Zip Code)
	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 [		 Place of Dispos cemetery, crem	ition (Name of atory or other pla	(ce)	Date	20c. Location - Ci	ty or Town, State
Baltimore,	permit. Pages Depertment of Important: If it any Injury or o		4 □ Donation 5 □ Other (Special Control of Special	ir) mo	1. Veta	Name and Addre	the same of the sa	12-071	scoulah	md.
Ba	permit. Depertrimports sny Injury		Sunch	Fork	911	1 W. 750	1 0 5	treat So	Mich +	m 21801
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	nplications that caused the dear one cause on each line.	th. Do not ente	r the mode of dyi	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
Į.	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consec	quence of):	mosis	S'			
	ť	ler	Sequentially list conditions, if any, leading to immediate	b. Kenal Due to (or as a consec	rau (	ure				
	and I-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	cDue to (or as a consec	Theore of).					
Box 68760,	ate be e hysician he buria	cal	(	d	400100 0.7.					
9 X O	nding pluse as t	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date (	of delivery
P.O. B	the death by the atte ached for	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c		Ectopic pregnanc Other (specify) _	у		Month	
	Attending Physician: The law requires that the death certificate be executed r death. ector: Alter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death but not res	sulling in the un-	derlying cause gr	ven iл Part I.			ute to the cause of death?
Division of Vital Records,	The law re te has be age 2 sho	Completed						24a. Was a autops perform	y price dea	ore autopsy findings available or to completion of cause of ath?
/ital	cian: ertifice ector, p	Be	25. Was case referred to medical examiner?			-		1 ☐ Yes 2		]Yes 2□ No
ot	ding Physician: The lav h. Alter this certificate has funeral director, page 2	n; To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpalient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3□ DDA Ott		Home 5 Reside	nce 6 □Other	
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<u>≥</u>	ital or Attenirs after deati	Certification;	4 Homicide determined	building, etc. (Specia	(y)			City or Towr	, State)	or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the tiestigation, in my o	me, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and mann ate and place, and	er as stated. If due to the cause(s)
	vithin 2 To the	Σ	29b. Signature and title of certifier	and MD		29c. Licens	se number	2	9d. Date signed (	Month, Day, Year)
. 7	Zu		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, P	rint)	10.597	J	10-(	1001.
,	Sta	0	Dr. Anupana 31. Dale filed (Month Day, Year)	Varadaro	jan	1715	Divis	sion St	Sal	08-2007. isbury
	Registr		31. Dale filed (Month Day, Year) 2	UU/ Brava	& for	me				,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician M WATT -05-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBUR WICOMICO COASTAL HOSPICE AT THE LAKE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)

Z - 3 - 1930 N. (Are) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Davs 1 ☐ M 2 🔀 F Hours 080-24-1163 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 Is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Salisbury 1 ☐Yes 2 No **Funeral Director** MARYLAND Wicomico 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21801 1503 DuchESS USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NowE Domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Williams HARRIS 2 Emma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and 2... ant of Health and 27 le Husband SALISBURY, Md 1503 21801 Dre. Howard DuchEss permit. Pages 1 an Department of Heal Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Gill 10-9-07 HEBRON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility any 8 tewar STEWER Home Salis, Md 21801 821 WEST Rd. FUN. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician MRTASTATIC LUNG CANCRIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO05 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX # 1733 SALISMURY UND 21802 GHULHMWARIS. COASTAL HOSPICA Registrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2007 OCT Registrar

		4	For	State of Mary	land /					ental Hy	/gien	е	
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/Med Exam		31	4a, Facility Name (If not institution, give	street and number)		T	4b. City, Town, or	r Location	n of Death	10	40	c. County of Dea	
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Funera			5. Social Security Number V 6. Se	THE OFF	yrs. last b	virthday) _ Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi	rth ay, Year	9. Bir C	thplace (State or Foreign ountry)
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yland now at			10a. State 10b. County	10	c. City, To	wn or Loc	ation						10d. Inside City Limits
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vith th	Director		10e. Street and Number 107 Moore Ave.				10f. Zip Code 21826	6			10g. C	itizen of What C	ountry?
eath v	Finaral	5	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. W	as Decedent of H		Origin? (Spe	ecify Yes or N	0-	14. Race - Am	erican Indian,
or iten			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No		l If	Yes, specify Cuba	an, Mexic	an, Puerto	Rican, etc.)		Black, Whi	1
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	2	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			∐Yes 2XINo	Specii	iy:			Specify: W	
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aryland 21215-0036 should be filed within 72 hours after death with the Marylan not Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	1	2	William Edward H	amilton						ances 1			
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'altimore, mit. Pages 1 ar ppartment of Hea pportant: If item 2			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □	Daniel fram Otata	cemet	ery, crem	ition (Name of atory or other place			Date	20c. l	ocation - City o	r Town, State
LIM Pag tment tant: I			4 ☐ Donation 5 ☐ Other (Specify	)	Capev	Ceme	U.M. Chi tery	urch	10/7	/07		peville	
Baltimo	Olice		21. Signature of Funeral Service Licen		CFSP	Ho 50	Name and Addre Olloway Ol Snow	ss of Fac Fune: Hill	ral H	ome Pro Salish	ofes.	sional A , MD 218	Association 304
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	death. Do	not ente	r the mode of dyir	ng, such	as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicia	_		Immediate Cause (Final disease or condition resulting in death)	a. Motast	til	Lu	_ 4	en	ar_	-			Onset and Death
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58760, icate be executed physician and s the burial-transit			resulting in death) Last	Due to (or as a co	onsequence	e of):							
58760 ficate be e physician s the buria	lesipe			d				_					
.O. BOX 6 the death certific y the attending p	Physician/Me		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p		+h 2□	Ectopic pregnance	.,				23d. Date of de	elivery
). <b>B</b> edeat	10.0		in the past 12 months? 1□ Yes 2□ No	4□Pregnant at tim			Other (specify)	у				Month	Day Year
P.O hat the id by th			9 ☐ Unknoy n  Part II. Other significant conditions of		ot resulting	in the un	derlying cause giv	en in Par	rt I.	23e. Did	tobacco	use contribute	to the cause of death?
Hecords, P.O. The law requires that the di the has been signed by the a	2	2		on a second to second second			zen,mg aaass gro			7	1		Probably 4 Unknown
w req	Completed									24a. Wa		24b. Were a	utopsy findings available
The 1st ate has	Į,									aut per 1∐ Yes	opsy f <del>orm</del> ed?	death?	
VITAL REC sician: The law s certificate has b irector, page 2 s	Be		25. Was case referred to medical examiner?						ace of Deatl	n (Check only	_		
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DIVISION OF  I or Attending Phy after death. Director: After this in by the funeral d	Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (5	- At home,	farm, stre	et, factory, office		-	28f. Location City or To			Rural Route Number,
ital or ral Dil													
DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	100		ysician: To the best of m niner: On the basis of ex and manner stated	amination a								
To t Com	N		29b Signature and title of certifier	20) 111			29c. Licens	e numbe	) 7C		29d. D	ate signed (Mor	th, Day, Year)
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S Regis	state strar		31. Date filed (Month-Day 5ar) 200	7 Registrar's	Signature	grax.				<i></i> )			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ,200 /Medical f not institution, give street and number) 4b. City, Town, or Location of Death Examiner (ent iandalls 1 MOVR Da 0001 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days Min. 1 □ M 2 X F Director Usual Residence of Decedent 10c City, Town or Location

Landall Stown death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a Carthage Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black Specify. ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem Z7 is marked other than "I any injury or other traumatic event, the Mec any injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12thgrade DOVVISOr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zeedie andall Stewart Willis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) Landallstown MD Koad Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State Baltimore National 26/07 4 Donation 5 DOther (Specify) ugun ( 21. Signature of Funeral Service Licenses . Greene Funeral sus Road Randallstown MD 21133 23a. Part 1. Entay the disease, or complications that caused the death. Do not enter the mode of dying, and shock, or heart for ure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Seas **Physician** QVO /Medical ue to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 ∃Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No has certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FNOutpatient 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide determined 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) No 0 32 Segistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 23a per dr., g873, 10/25/07/11/08/08/19 Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician WILLIAM AYERS 12, 2007 5:00 AM F. OCT. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 717 HOMESTEAD ST CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 241-28-5119 Director 88 VIRGÍNIA 9/20/1919 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Funeral Director MD CITY BALTIMORE 1XIYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 HOMESTEAD ST. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: WHITE 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION other Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F þe ELLIOTT **AYERS** McMILLIAN ANNTE Pages 1 and 2 should I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau EDNA WARD -COMPANION 717 HOMESTEAD ST., BALTIMORE, MD 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) WESTMINSTER CEMETERY 10/16/07 WESTMINSTER, 21. Signature of Fund val Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart felture. List only one cause on each line. Immediate Caus 4F al disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic Adenocarcinoma and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed this certificate 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation Injury To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Drawn Stulloner. D0058860 OCT 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 N. CALVERT ST. DHILLON MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 25 Registrar 2007

DHMH 17 Rev 1/2001

30

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

ELAINE

Physician

/Medical

Examiner

4b. City, Town, or Location of Death

**ABRAMS** 

2. Date of Death OCTOBER

8. Date of Birth

11/01/1931

21 2007

4c. County of Death

BALTIMORE

10g. Citizen of What Country?

U.S.A.

Specify:

16b. Kind of Business/Industry

OWN HOME

BALTIMORE, MD

SOL LEVINSON & BROS.. INC.

CanceR

14. Race - American Indian,

WHITE

MIZEN

Approximate Interval Between Onset and Death

weeks

Year

Black White etc

9:30

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 No

A M

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Loch Raven Blvd.

23d. Date of delivery

Day

Month

7 State

Medical

Registrar

Director: After

within 24 hours a To the Funeral D

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 0C 1 2 5 2007

5 ☐ Pending investigation

6 □Could not be

determined

Chow

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

RMB 500, 5601

how

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

29c. License number

item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10e. Street and Number 3802 Benson Avenue 21227 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No white Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be should be Marion Dill Risper Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a Richard Scheppske, Jr./Son 401 Silver Run Valley Rd. Westminster MD 21158 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Loudon Park Cemetery 10-24-2007 Baltimore, Maryland Department of Important: If any injury or once. = 5 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician comica /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-trar Due to (or as a consequence of) physician Physician/Medical the death certificate as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 16 24a. Was an has autopsy performed page After this certificate funeral director, pag or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 ☐ ER/Outpatient 3 ☐ DOA ۴ 1 [Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Deat 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. hours after death.

uneral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours after the Funeral Dire mpletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) singra. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien ? 34223 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 0 **Physician** 0 0 500 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 79 214-22-5207 Dec. 14, 1927 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code

			1 - For State Registrar	State of M	arylan	nd / Depa	artment e tificate	of Health of Deat	and M		jienę leg. No		(	34224
	Physici	an	Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Day	v Year		3. Time of Death
	/Medi		Inell			Bi	erron			Octobe	1 2	21 20	07	16:23 PM
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	Funeral Director		5. Social Security Number  231–42–9010  Usual Residence of Decedent	. Sex 7. Ag 1	74	last birthday) Yrs.		ays Hours		8. Date of Birth (Month, Day 6-11-1	, Year)	9. B	ountry	e (State or Foreign ) Va
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d	. Inside City Limits
	Mary -1 sh	ţō	Md. NA			Balt	imore							1 AYes 2 □ No
	r 28e	Director	10e. Street and Number				10f. Zip Co	ode		1	0g. Citi	izen of What (	Country	?
	h with	O IS	3532 Esther P	lace			2	1224				USA		
	deat deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Vas Deceden	t of Hispanic	Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - An		
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lar	2 2 3 3		19a. Informant's Name/Relationship							al Route Number			Zip Co	ode)
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ore	ges 1 ar t of Hea if item or othe		20a. Method of Disposition  1 Burjal 2 Cremation 3	□Removal from State		lace of Dispo emetery, cren	sition (Name natory or othe	of r place)	1	Date	20c. Lo	cation - City o	r Town	, State
Ē	Pa Int:		4 ☐ Donation 5 ☐ Other (Spe		'	Trinit	y Cem.		10-2	26-07	Dur	ndalk,	Md.	
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lic	ensee		22	. Name and A	ddress of Fac	cility N	March F.	н. н	East		
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	/Medical		resulting in death)	a. Due to ras		uence of):							7	days
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o	an an rial-tr		resulting in death) Last	Due to (or as	•	,								: .
8760	cate be executed physician and the burial-transit	dlcal		d. hypot	ensi	on at	ter au	ortic v	alve	relacen	me in	,t	14	days
89	ng ph as th	Med	IE ECMALC:											
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregr Other <i>(speci</i>				2	23d. Date of d Month	elivery Da	y Year
٥.	that the de led by the a detached		Part II. Other significant conditions	contributing to death h	uit not resi	ulting in the ur	deriving caus	e given in Par	rt I	23a. Did tol	nacco II	se contribute	to the	cause of death?
Division of Vital Records,	w requires to been signer should be	ted by								1	s 2[			y 4 □Unknown
ec	law r as be	ple								24a. Was a autops		24b. Were a	utopsy	findings available letion of cause of
<u> </u>		Completed								perforr	ned?	death?	· ~	≰ <sub>No</sub>
/ita	sicien: T certificat rector, pa	Be (	25. Was case referred to medical examiner?					26. Pla	ce of Death	(Check only on	e)			
Ž	Physicien: this certificanal director,	2	1 ☐ Yes 2 X No	Hospital: 12 Inpatie		ER/Outpatien			Nursing Ho	me 5 🗆 Reside	nce 6	3 □Other (Sp	ecify)	
ם ם		e :	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injui	ry y Year)	28b. Time of Injury		Injury at Work?		28d. Describe ho	w injur	y occurred		
sio	or: or:	catl	2 Accident investigat 3 Suicide 6 Could not	bo			М	1 ☐ Yes 2 [						
DİV	i i i i i	Certification;	4 Homicide determine		ury - At ho c. (Specify	ome, farm, stre	et, factory, or	fice		28f. Location (St. City or Town			Rural R	ou <b>te Num</b> ber,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier TS Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	t examınat	wledge, death tion and/or inv	occurred at t estigation, in	ne time, date my opinion, d	and place, eath occurr	and due to the ca ed at the time, d	ause(s) ate and	and manner a place, and du	s state	nd. e cause(s)
	Vithi To t Com	Σ	29b. Signature and title of certifier	, n				cense numbe		2	9d. Date	e signed (Mor	th. Da	v, Year)
			- Feel	~ Her	- 1	10		RES-	000		OCI	tober	21	,2007
	6		30. Name and address of person wh	o completed cause of d	leath (Item	23a) (Type, I	Print)	Main.	0+					Jaryland J21287
	7	<b>†</b>	31. Date filed (Month, Day, Year)	man MD	ar's Signat	ture.	prin	voite	SIR	el De	211	more		aryland
	Sta Registr		OCT 2	5 2007	J. S. C.	JA A								J21657

			For State Registrar	State of Maryland	d / Depa <i>Cert</i>	rtment of l tificate of	Health and <i>Death</i>	Mental Hy	giene Reg. No. 200	7 34225		
	Physici /Medi		1. Decedent's Name (First, Middle, Las GERTRUD MA	RIA EMILIE BIF	RKHOLZ			2. Date of De Month Octobel	_Day _ Yes	3. Time of Death 7:20P M		
	Examir		4a. Facility Name (If not institution, give STELLA MARIS HOS			4b. City, Town, o	or Location of Dea	th	4c. County of Death Baltimore County			
	Funeral Director		5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Year Months Days			h 9.1	Birthplace (State or Foreign Country) Germany		
23; 2007 7:20 p.m. , Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A  10e. Street and Number 6205 The Alame  11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Hans  19a. Informant's Name/Relationship (TAXel Wolff (Pe	cud Rural Route Numb	10g. Citizen of What  USA  14. Race - A Black, W Specify:  16b. Kind of Busine  Legal  Maiden Surname)  Sand  er, City or Town, State Bridge,	merican Indian, hite, etc.  White ss/Industry  mann e, Zip Code)						
OCTOBER 2	permit. Pages 1 a Department of He Important: If item any Injury or oth		20a. Method of Disposition  1 Burial 2 XiCremation 3 4 Donation 5 Other (Specify  21. Signation 5 Succelus Flartin D. Law	Removal from State	en Mour	ition (Name of atory or other pla nt Crema Name and Addro ICHELL-W	itory 10/ ess of Facility /IEDEFELD	Date  /26/07  FUNERAL	Baltimore, HOME, INC Maryland	or Town, State Maryland		
8760,	Physician and /Medical Examiner the prival-transit	dical Examiner										
BIRKHOLZ Is, P.O. Box 68	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as if	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □6	Ectopic pregnanc Other (specify) _	ey		23d. Date of Month	delivery Day Year		
E BIRK ords, P.	w requires that to be signed by should be detail	ted by Ph	Part II. Other significant conditions of	ontributing to death but not resul	lting in the und	derlying cause gi	ven în Part I.	10'	Yes 2□ No 3□	e to the cause of death?  Probably 4X1Unknown		
GERTRUDE BI Vital Records,	sician: The law scertificate has birector, page 2 st	Completed	25. Was case referred to medical				00 81	1□ Yes	osy prior rmed? death 2 No 1 □ \			
G Division or Vit	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At hor	ER/Outpatient 28b. Time of Injury me, farm, stree	28c. Inju Wo M 1	her: 4 □ Nursing ry at rk? ] Yes 2 □ No	28d. Describe I	dence 6 NOther (Snow injury occurred	pecify) HOSPICE  Rural Route Number,		
Div	spital or /		29a. Certifier 1 X Certifying Rby	building, etc. (Specify,	vledge, death	occurred at the t	ime, date and pla	City or Tox	cause(s) and manne	as stated.		
	o the Ho ithin 24 t o the Fu	Medical	(Check only one)  29 Medical Examone)  29b. Signature and title of certifier	iner: On the basis of examinati and manner stated.	ion and/or inve	estigation, in my 29c. Licen			date and place, and a 29d. Date signed (Miles)			
	F 3 F 8		•			1	)437	25	10/24			
	10		30. Name and address of person who co				TIMONIUM	, MD 2109	93			
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 5 20	32 Registrar's Signat	ure A							

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U1	-0	10	46	}

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Kenneth E. Bean		r, 1- For State	Sta	ate of Maryland		rtment of tificate of		d Menta			200	7	3422
Physicia		Registrar 1. Decedent's Nar	ne (First, Middl	e,Last)		imodio oi	Dougn		2. Date of De	Reg. No. ath		3. Time of	
Medical Examin			Kenn	eth E. Be	ane.	Jr.			Month October	Day Y	ear	2039	hrs
		,	(if not institution County H	n, give street and number	er)	4	o. City, Town, or Hagerstown		Death	4c. County of Death Washington			
Funeral		5. Social Security			Age (In yrs. la	ast birthday)	If Under 1 Yea		24Hrs. 8. Date of B	irth(MM/DD/YY			ate or
Director		219.50.	5626	1 <b>X</b> M 2 F	<b>59</b>	Yrs.	Months Day	s Hours	Min. 2/24/	1948	Foreigr Cou	ntry)	N C
à		Usual Residence	of Decedent 10b. County		10c City	Town or Location	n .		_			10d. Insid	le City Limits
nd show any ice.	٦	MD	How	ard	,,,,			llic	ott City			1Ye	s 2 <b>X X</b> No
thours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.	Director	10e. Street and N					10f. Zip Code			10g. Citizen of	What Count	try?	
ith the			5 Sam	antha Way		S 142 Wes	2 Sansify You or N	USA No- 14. Race - American Indian, Black,					
eath wi	Funeral	11. Marital Status  1 Never Mari	ried 2 X Ma	12. Was Decede	es?	.S. If Ye	s, specify Cubar	? ( Specify Yes or Nouerto Rican, etc.)	14. Ra	nite, etc.	an indian	, black,	
after do	by Fu	3 Widowed	4 Div	1 Yes  orced If Yes, Give Year or Dates:	2 <b>X</b> No		Yes 2 X No		Specif				
hours 'natur Exam		15. Decedent's E		cify only highest grade of College (1-4)			s Usual Occupa st of working life			16b. Kind of	Business/In	dustry	
D36 thin 72 ne. than	Completed	Elemental y/Sec	condary (0-12)	5+	01 51)	Math	ematic	ian		Mai	thmat	ics	
5-0036 iled within 77 Hygiene. I other than the Medical		17. Father's Name		•	_	<u> </u>			Name (First, Middle		•		
2121 ould be fi Mental ] marked	Be	Ken 19a. Informant's N		E. Beane,	Sr.	10h Mailing	Address (Strat		nnie Mar er or Rural Route N				,
MD 2 Ind 2 shoul filth and N m 27 is m aumatic	٩			O'Rourke	wife								
re, N l and l'Healtl f'item	Ì	20a. Method of Di	sposition	3 Removal from		Place of Disposi crematory or oth	tion (Name of ce er place)		Date Date	1			1
Baltimore, permit. Pages 1 ar Oepartment of He Important: If ite		1 Burial 2 4 Donation	process of the same of the sam	_		estlawr	1	- 1	10-/19/0				lle, M
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of F	uneral Service	Licensee	NINZ	22. N	ame and Addres	s of Facility	Slack Fu mbia Pik	neral	Home 2104	3 P	. A .
Physician	一	23a. Part L Enter	the disease, or	complications than caus on each line.	sed the death	. Do not enter th	e mode of dying	, such as car	diac or respiratory a	rrest, shock, or	heart	Approxi	mate Interval en Onset and
M-dical xaminer	1	Immediate Cause	(Final disease	a. Chest and ab	dominal ir	njuries					- 8		Death
		or condition resul		Due to (or as a co	nsequence o	of):							
	ē	Sequentially list of if any, leading to it coulse. Enter this	immediate	Due to (or as a co	nsequence o	f):							
	Examiner	(Disease or injury events resulting in	that initiated	Due to (or as a co	nsequence o	of):							
executed an and al - transi				d							-	-	
50, te be ex ysician burial	ledical	UNPENDE	D	AMENDED 23c. If yes, out	name of area					23d Date	of delivery		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	cian/Me	IF FEMALE: 23b. Was deceder past 12 monti		e 1 Live birth	1	2 Fe	al death 3	Ectopic <sub>j</sub>	oregnancy	Month		ay	Year
Box (e death ce the attenced for use	· <u>s</u>	1 Yes 2	No 9 Uni		t at time of de	eath 5 Oth	er (Specify)						
Records, P.O. Box 6876C The law requires that the death certificate I cate has been signed by the attending physpage 2 should be detached for use as the by	/ Phy	Part II. Other sign	nificant condit	ions contributing to de	eath but not r	esulting in the u	nderlying cause	given in Part		tobacco use co		-	_
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n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach	Completed									s an 24 opsy formed?			ings available of cause of
	Con								1 🗸 Yes		1 🗸 Ye	s	2 No
of Vital Recing Physician: The land After this certificate land director, page	Be	25. Was case reference:		Hannital:	atient 2 🗸	ER/Outpatient		Othor:	Check only one)  Nursing Home 5	Residence	6 Other	:	
of \ng Phy	2	1 ✓ Yes 27. Manner of De	2 No ath	28a, Date of	Injury	28b. Time of I		ury at Work?		e how injury oc notorcycle s		nar nar	
ttendii death ctor: /	atio	1 Natural 2 ✓ Accident	5 Pend Inve	stigation		1800 hrs		Yes 2	NO				
Division pital or Attendii ours after death eral Director: /	Certification:	3 Suicide		d not be	• •	ome, farm, stree	t, factory, office	building, etc.		(Street and Nu , State) ad, Hagersto		ral Route	Number, City
Ell el on bi		4 Homicide 29a. Certifier (Check only	Certifying P	nysician: To the best o	f my knowled	d / Highway	ed at the time, d	late and plac	e, and due to the ca	use(s) and mar	ner as state	ed.	
To the Hos within 24 h To the Fun completely	edical	one) 2	Medical Exa	miner:On the basis of e	examination a	and/or investigat	on, in my opinio	n, death occi	urred at the time, da	te and place, ar	nd due to the	e cause(s	)
F 3 F 8	ž	29b. Signature an	d title of certific		)		29c. Licen			29d. Date s			/ear)
		(alsi	ell	1/1		- 00-1	0.0	.M.E.		October	12, 200		
5		30. Name and add		who completed cause Assistant Medical	•		n Street, Bal	timore, M	D 21201				:
Sta		31. Date filed (Mo	nth, Day, Year)	32. Regis	strar's Signat	ure	E P		C	CME	-		

O7-08044 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Harrell Louis Bosley, Jr. State of Maryland / Department of Health and Mental Hygiene									
Harrell Louis Bosley	, Jr. State of Maryland / Department of 1-For State Certificate of	Dooth	2007 3422						
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dear	th 3. Time of Death						
Medical Examiner	Harrell Louis Bosley, Jr.	Month October 1	5, 2007 0840 hrs						
	4a. Facility Name (if not institution, give street and number)  3004 B Autumn Branch Lane	b. City, Town, or Location of Death  Ellicott City	Howard						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 2 1 4 - 4 6 - 0 8 2 6 1 X M 2 F 6 0 Yrs.	If Under 1 Year   If Under 24Hrs.   8. Date of Bir   Months   Days   Hours   Min.   8 / 2 9 /	rth(MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) Panama						
	Usual Residence of Decedent		10d. Inside City Limits						
d how any	10a. State 10b. County 10c. City, Town or Location MD Howard	Ellicott City	1 Yes 2 No						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e Street and Number 3004 B Autumn Branch Lane	10f. Zip Code 1 2 1 0 4 3	log. Citizen of What Country?						
with the s 23a o c notifi	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? ( Specify Yes or No	o- 14. Race - American Indian, Black,						
er death with , or items 23 r must be no	1 Yes 2 X No	es, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc. White						
s after rral", c	or Dates:	Yes 2 X No specify: 's Usual Occupation (Give kind of work done	Specify:  16b. Kind of Business/Industry						
5-0036 ed within 72 hours lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired)							
5-0036 iled within 77 Hygiene. I other than the Medical		sabled	Disabled						
215-C be filed v intal Hygi rked othu ent, the l	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,							
212 212 213 214 217 215 215 215 215 215 215 215 215 215 215		Address (Street and Number or Rural Route Nu	mber, City or Town, State, Zip Code)						
MD and 2 sho alth and m 27 is aumati	Ms. Betty Bosley mother PO Bo	OX 250 Junction CI	ty, CA 96048						
Ore, es 1 an of Hee If ite	1 Burisl 2 V Cremation 3 Removal from State crematory or oth	ner place)	1						
Baltimore, vermit. Pages I ar Department of Hee important: If itee		Crematory 10/23/0							
Ba perm Deps Imp	11/0 m 1/2/1/02/2012/10/12/2012/38:	71 Old Columbia Pik	e, MD 21043						
Physician Medical	23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac or respiratory ar	rrest, shock, or heart Approximate Interval Between Onset and Death						
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		Dodan						
	Sequentially list conditions, b								
in a sine	if any, leading to immediate Due to (or as a consequence of):								
cecuted and transit	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
e executorian and rial - tran	UNPENDED AMENDED								
760, icate by physic the but	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial confined Certification: To Be Completed by Physician Medical	past 12 months?    1   Live birth   2   Fe     4   Pregnant at time of death   5   Ot	her (Specify)							
D. Bo the deat by the at	Part II. Other significant conditions contributing to death but not resulting in the c	inderlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?						
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ranger death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.			es 2 No 3 Probably 4 Unknown						
Records, The law requires ficate has been sign, spage 2 should be		24a. Wa	opsy prior to completion of cause of						
eco he law ate has age 2 s		peri	formed? death? s 2 No 1 Yes 2 No						
tal R cian: T certific rector, p	25. Was case referred to medical	26.Place of Death (Check only one)  Other  Nursing Home 5							
f Vit	1 V Yes 2 No Inpatient 2 Erroutpatient	Taleng Halle	Residence 6 Other: Scene e how injury occurred						
on on on the function of the function.	1 Natural 5 Pending FOUND: Poury Pending Oct 15, 2007 0815 hrs	1 Yes 2 ✓ No Subject sh	not self						
Division o Spital or Attending nours after death meral Director: After filled in by the fune	2 Accident Investigation Oct 15, 2007 0815 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	or Town,	(Street and Number or Rural Route Number, City State)						
Division of Vital Rectiviting 24 hours after death within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, page redicted Certification. To Be Completely			umn Branch Lane, Ellicott City, MD						
To the Ho within 24 To the Fu completely	29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation.	red at the time, date and place, and due to the ca tion, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)						
To a source of the state of the		29c. License number	29d. Date signed (Month, Day, Year)						
	Jasha Gelf nin	O.C.M.E.	October 16, 2007						
9	30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21201							
Stat	00= 0 11 000 11 11 11 11	<i>d</i> .							
Registra DHMH 17 Rev 1/200	OCT 2.5 2007 Logical ORIGINA	AL							

			For State Registrar	State of Maryland	/ Depa <i>Cer</i>	artment of tificate o	Health a f Death	nd Mei		ene200	7 3	3422	8
	Physici		1. Decedent's Name (First, Middle, Last)  John C. Christ	lan				2.	Date of Death Month Q / 1		/ear	3. Time of Dea	
	/Medic Examir		4a. Facility Name (If not institution, give str 5805 42nd Avenue	e <b>,</b> #710		Hyatt	or Location of			4c. County of Prince	Death Geo	rges	
	Funeral Director		5. Social Security Number 6. Sex 577-56-6455 Social Residence of Decedent	7. Age (In yrs. last	Yrs.	If Under 1 Ye Months Day		Min. 8.	Date of Birth (Month, Day, ) 11/1/		Birthplac Country ash.	DC	reign
	Maryland a-f ahow	ctor	10a. State 10b. County MD Prince Ge	eorges Hya	own or Loc						10d.	Inside City Li	
	th with th	ai Director	10e. Street and Number 5805 42nd Avenu	ie, #710		10f. Zip Code	20781		10	g. Citizen of Wh USA	p. Citizen of What Country?  USA		
980	72 hours after death with the Maryland Insturel', or iteme 23a or 28a-f show disal Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 XNo		Nas Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica I ☐ Yes 2☑ No Specify:			/ Yes or No- an, etc.)	Black,	American White, etc Bla		
Maryland 21215-0036	within liene. r then	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Cab Driver			10	6b. Kind of Busi		stry		
land 2	be filed Ital Hygi od other avent, I	To Be Co	17. Father's Name (First, Middle, Last) Roscoe J. Christ	ian, Sr.		ab Dri	18. Mother		ame (First, Middle, Maiden Sumame) A. Brooks				
	S D E E		19a. Informant's Name/Relationship (Type Roscoe Christian			_				City or Town, St		ode)	
	Pages 1 and 2 nent of Health a int: if item 27 is iry or other tree		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)	20b. Plac cem	e of Dispos etery, crem	sposition (Name of remailory or other place)  ection Cem. 9/19/07 Clinton, MD							
Balt	permit. Page Depertment of Important: if any injury or once.	4	21. Signatur of Funeral Service Licens	ssion	al Fu	neral Wash.	Serv	ice	n				
8760,	death certificate be executed  Nedicial and certificate be executed to the burial-transit of for use as the burial-transit of the property of	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Arterioscl Due to (or as a consequent	erot ice of):		-				In	pproximate terval Betweer nset and Deat	
P.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date of Month	,	iy Year	
	w requires thet the been signed by th should be detache	þ	Part II. Other significant conditions contr Diabetes	buting to death but not resulting	ng in the un	derlying cause	given in Part I.			cco use contrib			
Division of Vital Records,	The law ste has b page 2 s	e Completed	25. Was case referred to medical				00 81			priced dead dead No 1 [	or to compl ath?	findings avail letion of cause	able of
Į.	S 5	ToB	examiner?	spital:	/Outpatient	3 DOA	other		<i>heck only one</i> 5 <b>⊠</b> Residen	ce 6 ☐Other	(Specify)		_
sion o	Jing After fune		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. In W M 1		28d		injury occurred			
Divi	Ital or Att rs efter d rai Direct led in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	street, factory, office 28f. Location (Street and Number or Rural Ru City or Town, State)					oute Number,		
	tha Hospital or Attandin 24 hours effer death tha Funeral Director: npletely filled in by the	Medicai	(Check only 2 Medicel Examine	ian: To the best of my knowle r: On the basis of examination and manner stated.	dge, death and/or inv	estigation, in m	y opinion, death	place, and occurred a	due to the cau at the time, dat	se(s) and mann e and place, and	er as state d due to the	ed. e cause(s)	
)	To the within To the comple	~	29b. Signature and title of certifier	Alasto.	00	н0	055927	7		d. Date signed (			57
	5		30. Name and address of person who com Salvador Sylves 31. Date filed (Month, Day, Year)	ter, MD 255	Roc	ckville	e Pike	, Su	ite 12	.5, Roc	2 kvil	0850 Lle, M	iD
DI	Sta Registr	ar	OCT 2 5 2007	Salegistrar's Signature		WE .							

State of Maryland / Department of Health and Mental Hygiene O 7

Certificate of Death 34229 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** CHADWICK OCTOBER 2007 8:00 AM BERNETTA /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Mogra 64) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Couldaryland **Funeral** Sex 1□M 2□F 215-66-3616 50 Director Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic svent, the Medical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore Maryland 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1019 Howland Square 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 20 No Baltimore, Maryland 21215-0036 If Yes, Give Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use religed)

Disabled 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Never Worked** Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) Lottie Johnson 17. Father's Name (First, Middle, Last)
Stanley Johnson Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Riwal Route Number, City or Town, State, Zip Code) 1019 Howland Square Baltimore, Maryland 21227 Larry Chadwick Husband 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of 20c. Location · City or Town, State Garrison Forest Veterans Cemetery 10/29/07 Owings Mills, Md. 4 ☐ Demation 5 ☐ Other (Specify) of Funeral Service License 22. Name Ested Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature 23a. Part 1. Enter the disease, or producations that caused shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 24 hours /Medical Due to (or as a consequence of) Examiner 4 months pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit HIV/AIDS UNKNOWN Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has funeral director, page 2: autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 21, 2007 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltmore, MD 21224 DURAND INE DR CHRIST 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene2007For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:30 A M 2007 Dorothy B. DeLuca October | 24 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Ellicott City Howard Morningside House if Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛛 F Yrs. Maryland 1923 Director 219 16 5089 83 Usual Residenca of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nen of Health and Mental Hygene.
sent if item 72 Is marked other than "natural", or itema 23s or 28e-1 show ury or other traumatic avent, the Medical Examines out the traumatic avent, the Medical Examines out the traumatic avent. 1 ☐ Yes 2 No Directo Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21122 773 Bridge Drive Completed by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A & P\_Food Store 10 Bookkeeper 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Catherine Ziegler Carroll Tierney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel A. Erickson/Son in law 2935 Pebble Beach Drive Ellicott City, MD 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Importent: I any injury o once. '4 □Donation 5 XtOther (Specify) entombment Crest Lawn Mem. Gard. 10-30-2007 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 hattery 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
3 m onthis Immediate Cause (Final disease or condition resulting in death) Physician Car /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 😧 No O 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown UNKNOWN 24b. Were autopsy findings available prior to completion of cause of death? LESION 24a. Was an autopsy performed? LUNG 1 Yes 1 Yes 2 (NO Hospitel or Attending Physician: 25. Was care referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 DOther (Specify) asst. live Medical Certification: To 1 Yes 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending Injury 1 Yes 2 No death. investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21613 October 25, 2007 30. Name and address of person who completed cause of de in (Item 23a) (Type, Print) 2 24A magating Beach Rd Pascalera MD 21122 31. Date filed (Month, Day, Year) State 25

DHMH 17 Rev 1/2001

Registrar

200

## 1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

34231

- Physician
/Medical
Examiner

**Funeral** Director

show ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Medic once.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records.

**Physician** /Medical **Examiner** 

attending physician and for use as the burial-transit To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Karl Emil Endryas 8:30 AM 24,2007 October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Weyfield Court Baltimore Rosedale 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days 1**∑**M 2□F Months Hours Min. 015-24-3055 January 16, 1933 Boston Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Baltimore Rosedale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Weyfield Court 21237 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼Yes 2□No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Bethlehem Steel 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix J. Endryas Josephine Racocha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 9 Weyfield Court, Rosedale, Maryland Jacqueline Jane Endryas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Creamtory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD. 25, 2007 . Signature of Funeral Service Licenses 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Lart1 Enter the disease, or complicatens that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) moth Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier G G MC 6701 N. Chules St Bolto. ML 21208 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GOLBERG AWRENCE Vear 5: 40 AM OCTOBER ž 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NORTHWE ST HOSPITAL RANDALISTOUN BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Manthe Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex 14 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 124-14-9309 82 FEB 20 1925 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Baltimore Owings Mills 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 4 Flocks Court 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married f Yes, Give /ear or Dates: WWTT 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Linen Delvery Driver Linens 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samue1 Goldberg Betty UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Hershfeld - daughter 6 Huntfield Court, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 10/22/07 Baltimore, MD 21. Signature of Funeral Service Mosses et H. Williams Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AIMBMA disease or condition resulting in death) Due to (or as a consequence of): GASTROINTESTINAL BLEEDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician attending p this after death To the Hospita. ... within 24 hours after To the Funeral Dir

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be nonce.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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Physician/Medical

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Be Completed

Certification: To

Medical

29a. Certifier (Check only one)

the Maryland

State

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and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUN

5401

OCTOBER 20 2007 OLD COURT ROAD RANDAUSTONN MD 21133

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier



Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20,2007 Month **Physician** October 5:50 P M R. Guice Elaine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2909 Salisbury Avenue Edgemere If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🛣 F New York 215-16-7307 January 28,1920 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 □Yes 2√ No Director Maryland Baltimore Edgemere 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 21219 USA 2909 Salisbury Avenue 23a the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: þ 3X Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If Item 27 is marked other that any injury or other traumatic cover-Education School Teacher 6 years 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Irene Patterson Clarence Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9132 Avenue C, Edgemere, Maryland 21219 Daughter Deborah Lutz 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 22 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Idigathic Relmonory Physician disease or condition resulting in death) /Medical Due to 4 r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760 physician pe Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Cardio Varadar Diseux 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Athero schustu Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 4 hours after death. Funeral Director: / death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 🗶 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier wh )ww 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Point Rd. Baltimer 124 31. Date filed (Month, Day, Year) State OCT 2 5 2007 Registrar

# JANICE GORDON Baltimore, Maryland 21215-0036

	/Me
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	19.00
il Records, P.O. Box 68760,⊸≲	The law requires that the death certificate be executed
r Vita	hysiclan:
Division o	To the Hospital or Attending Physiclar within 24 hours after death.

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		Registrar  1. Decedent's Name (First, Middle, La	ist)		Certino	ale of L	Jealli	Re 2. Date of Death	g. No.	3. Time of Death			
Physici /Medic		JANICE	ESS	SA				OCTOBER 22 2007 4:55 A					
Examin	ier	4a. Facility Name (If not institution, giv JEWISH CONVALES				BALTIN	Location of Death		4c. County of Death  BALTIMORE				
Funeral Director		5. Social Security Number 6. S							Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MD				
- A		Usual Residence of Decedent						07/20/1					
a-f shov	ctor	MD 10a. State 10b. County BALTIMO		BALTIMORE					10d. Inside City Limits 1 □ Yes 2 No				
vith the	Director	10e. Street and Number	,	10f. Zip Code				10	g. Citizen of What	Country?			
eath v	Completed by Funeral	7920 SCOTTS LEV	EL ROAD  12. Was Decedent Ever					ecify Ves or No-	U. S.	.A.			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Forces? If Yes, specify Cuban', Mexican', Puèrto 2 M No 1 □ Yes 2 No Specify:				Rican, etc.)		vhite, etc. WHITE			
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mit. Pa partmer <b>sortant</b> / Injury 2e.		4 ☐ Donation 5 ☐ Other (Special Sign rure of Funeral Service Lice	nsee	ARRIS	N <sub>22</sub> FOR	EST <sub>Addres</sub>				OS., INC.			
permii Depar Impor any Ir		) atus (X	emina				STERSTOWN	ROAD -	PIKESVILI	E. MD 21208			
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on fach line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
eath certificate be attending physicia for use as the bur	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23d. Date of delivery Month Day Year									
w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlyir	ng ca <b>us</b> e give	en in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Unknown			
The law recate has bee page 2 shou	Completed		1					24a. Was ar autops perform 1 Yes 2	y prior				
siclan: Th certificate rector, paq	Be	25. Was case referred to medical examiner?	Hospital:			Othe	er:	h (Check only one					
g Phys er this eral dii	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. T	patient 3 ime of njury	28c. Injur	4 Nursing Ho		nce 6 Other (S w injury occurred	Specify)			
or Attending F ifter death. Director: After in by the funera	Certification:	1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	00 280 Place of injury	Yes 2□No	28f. Location (Str. City or Town		r Rural Route Number,						
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier   1 Certifying Pl	hysician: To the best of m miner: On the basis of exa and manner stated.	y knowledge amination and	, death occur d/or investiga	red at the tir tion, in my o	me, date and place opinion, death occu	and due to the carred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)			
To T To t	Σ	29b. Signature and title of certifier	Locho	u'		29c. Licenso	e number 28595	29	Od. Date signed (M	(A)			
b Sta	ite_	30. Name and address of person who TASNEM 31. Date filed (Month, Day, Year)	AKI+17W1, 5	835	On IT	74 /	AVE, S	UITE 21	3, BAC	10 MD 21269			
Registr		OCT 2 5 20	24	B.	fresh	9							

07-07193 Kelly L Hunter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	cate of L	Death		Reg	No. 200	1/ 3423	
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Death     Month	ay Year	3. Time of Death 0332 hrs	
dical Exami	ner	Kellony La-Tisa Hunt 4a. Facility Name (if not institution, give street and num	er er	146	. City, Town, or I	ocation of Death	Month E September	16, 2007 4c. County of Death		
		Southern Maryland Hospital Center	<b>B</b> ol <sub>/</sub>	1	Clinton	;		Prince George	T I	
Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last bi	rthday)	If Under 1 Year		_	MM/DD/YYYY) 9. Birt		
Director		578-98-1191 1 M 2xF		29 Yrs.	Months Days	Hours Min	02/1	8/1978 Was		
any.		10a. State 10b. County	10c. City, Tow						10d. Inside City Limits	
	5	DC	Washi	ngtor	n			1 X Yes 2 No		
with the Maryland s 23a or 28a-f show a e notified at once.	Director	10e. Street and Number 638 14th Street NE			10f. Zip Code 20002	2	109	. Citizen of What Cour US		
death v	y Funeral	1 X Never Married 2 Married Armed For 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	dent Ever in U.S. ces?	If Yes	Decedent of His s, specify Cuban, res 2 No	Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc. Specify: B1	ack	
ours a atura xamin	d by	15: Decedent's Education (Specify only highest grade	completed) 16a	. Decedent's	s Usual Occupati st of working life.	on (Give kind of		6b. Kind of Business/I	ndustry	
5-0036 led within 72 h Hygiene. other than "n	omplete	Elementary/Secondary (0-12) College (1~9th	4 or 5+)	during mos	None	DO NOT use rea	red)	Non	е	
	Ве Со	17. Father's Name (First, Middle, Last) Stephen Hunter			1		e (First, Middle, Ma ene Tui			
AD 2 sho 27 is imati	10	19a. Informant's Name/Relationship (Type, Print ) Charlene Turner/Moth						er, City or Town, State Sh., DC 2		
more, M Pages 1 and 2 rent of Health nnt: If item 2		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from		e of Dispositi atory or othe	ion (Name of cen er place)	netery,	Date	20c. Location - City or	Town, State	
Page ment c		4 Donation 5 Other Specify:					01/07	Suitland	d, MD	
Baltimore, permit, Pages 1 at Department of Her Important: If ite injury or other tr		21. Signature of Furfer   Service Licers e	278	Rec	me and Address	fessio	nal Fun	eral Ser	vice	
Physician		23a. Part I. Enter the disease, or complications that ca	used the death. Do	1360 not enter the	5 14th e mode of dying,	Stres such as cardiac	or respiratory arres	ash DC '	2 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1	
/Medical	į į	failure. List only 'one cause on each line.  Immediate Cause (Final disease a. Multiple Inju				Sugar Stra	τ.		Between Onset and Death	
xaminer			consequence of):			in the state of th	20			
	r.	Sequentially list conditions, if any, leading to immediate Due to (or as a condition)	consequence of):							
	Examiner	cause. Enter Underlying Cause					1			
ted 1 insit	Exa	events resulting in death) Last Due to (or as a	consequence of):							
execuian and	Medical	UNPENDED AMENDED								
760, icate be executed physician and the burial - transit	Med		utcome of pregnanc	у				23d. Date of deliver	y	
68 ertif ding	sician	23b. Was decedent pregnant in the past 12 months?	th int at time of death	- =	al death 3 ( er (Specify)	Ectopic pregn	ancy	Month	Day Year	
Box e death c the atten ed for us	Physi	1 Yes 2 No 9 V Unknown 9 Unknown	<b>v</b> n	V Our	er (opcony)			1.		
<b>→</b> ⇒ > 5 5	by P	Part II. Other significant conditions contributing to	death but not result	ing in the ur	iderlying cause g	iven in Part I.		acco use contribute to	the cause of death? bably 4 Unknown	
cords, P.C. law requires that has been signed to e 2 should be deta	ed k		<del></del>				1 Yes		utopsy findings available	
corc law rechas be 2 shou	Completed						autops perforr	y prior to	completion of cause of	
Re( The icate	Con						1 <b>✓</b> Yes 2		es 2 No	
Vital ysician his certi director	Be	25. Was case referred to medical examiner?	patient 2 🗸 ER/	/Outpatient		of Death (Check Other, Nurs		Residence 6 Othe	r:	
on of Vital Records, ending Physician: The law requir path. or: After this certificate has been s the funeral director, page 2 should I	): To	27. Manner of Death 28a. Date of	of Injury 28t	o. Time of In		ry at Work?	28d. Describe h	ow injury occurred		
ion tendir eath. or: A	atior	1 Natural 5 Pending Sep 16, 2	2007 02	47 hrs	1`	Yes 2 ✔ No	Passenger a	uto collision		
Division  To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: /	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, Major Road / I		t, factory, office b	ouilding, etc.	or Town, St		ural Route Number, City	
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis on and manner st	f examination and/o							
F 3 F 8	Me	29b. Signature and title of certifier	atou.		29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)	
		Jointa Jee	g mo	,	O.C.	M.E.		September 16, 2	2007	
		30. Name and address of person who completed cause Tasha Greenberg MD. Assistant Me	edical Examine		Penn Street,	Baltimore, M	ID 21201			
	tate	DOTA P DOOT	gistrar's Signature	do						
Regis HMH 17 Rev 1/2		GOT & G 2007   AM	0	RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08253 State of Maryland / Department of Health and Mental Hygiene 2007 34236 Jeffrey Dale Hooper Certificate of Death Reg. No 1- For State Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day October 23, 2007 1843 hrs Physician/ Jeffrey Dale Hooper Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 1828 Manor Green Court Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** CountryMaryland March 22 Director 60 1 X M 2 212-50-3902 10d. Inside City Limits Usual Residence of Decedent 10c, City, Town or Location 10a. State Yes 2 X No Anne Arundel Maryland Annapolis 10g. Citizen of What Country? hours after death with the Maryland Director 10f, Zip Code 10e. Street and Number USA 21401 1828 Manor Green Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No Funeral 12. Was Decedent Ever in U.S. White, etc. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 2 X No Specify: White Yes Yes 2 X No specify If Yes, Give Yea Divorced Widowed the Medical Examiner 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry "natural", ð 15. Decedent's Education (Specify only highest grade completed) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natinjury or other traumatic event, the Medical Examinjury or other traumatic event, the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Examinical Programments of the Medical Programments o Completed College (1-4 or 5+) Elementary/Secondary (0-12) Accounting Controller 4 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Helen Vincent G. Carroll Hooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1828 Manor Green Court Annapolis, Wife Marie Hooper, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Removal from State Baltimore, Maryland Burial 2 X Cremation 3 10/25/07 Metro Crematory Inc. Donation 5 Other Specify: <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Signature of Funeral Service Licensee
Thomas Gregor and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Asphyxia Immediate Cause (Final disease xaminer Due to (or as a consequence of) or condition resulting in death) b Inhalation of automobile exhaust complicating atherosclerotic Sequentially list conditions Due to (or as a consequence of): cardiovascular disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED 28a-f. perME.g875, 1/17/08 TT by the attending physician tached for use as the burial PII,27 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE. Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 Unknown Completed by Oxycodone and cyclobenzaprine use 24b. Were autopsy findings available 24a. Was an prior to completion of cause of peen autopsy death? performed? this certificate has No Yes 2 26.Place of Death (Check only one) e Hospital or Attending Physician:
124 hours after death.
e Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medica Other<sub>4</sub> Division of Vital Residence 6 V Other: Scene Be Nursing Home 5 examiner? Hospital: Inpatient No 28d. Describe how injury occurred 1 Yes 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) subject inhaled auto exhaust in garage 27. Manner of Death Certification: Yes 2 X No Natural Fnd 6:37 pm Pendina 10/23/2007 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident Town, State or Town, State) 1828 Manor Green Ct. Annapolis,MD Could not be зХ Suicide (Specify) single family residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Homicide within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier October 24, 2007

OX PUI State

32. Registrar's Signature

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

Registrar

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

07-08203 Vern

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

on Higgs	1-	For State	State	of Maryland	/ Depart	ment c ficate c	if Health and If Death	i Menta	Re	g. No	20	3. Time of Death	423
Physician		egistrar . Decedent's Name	e (First, Middle,Las	it)					2. Date of Death Month October 2	Day Y	ear ,	1752 hrs	
Examine	er	_	non		Higo	gs	4b. City, Town, or	Location of I		4c. Count	ty of Death		
	4			e street and number	')		Baltimore C				NA		
	4	Johns Hopk	ins Hospital	ex 7. A	ge (In yrs. last	birthday)	If Under 1 Yea			th(MM/DD/YY	YY) 9. Birth Foreign	nplace (State or	
Funeral Director	°	214-68-2		M 2 F	49		rs. Months Day	s Hours	Min. 5-29-	1958	Cou	intry) Md	
Biledioi	-	Jsual Residence of	-									10d. Inside City	Limits
any	_	0a. State	10b. County		10c. City, T							1 X Yes 2	No
	5	Md.	NA	<u> </u>		Balti	more		11	0g. Citizen of	What Cour	ntry?	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Nu	ımber							USA			
th the		3605 Mot	nteray Ro	12. Was Decede	ot B ent Ever in U.S	i. 13. <sup>1</sup>	21218 Was Decedent of H	isnanic Origi	n? (Specify Yes or N	o- 14. R	ace - Ameri Vhite, etc.	ican Indian, Blac	k,
ath wit			ried 2 Marrie	A d Cores	2 No	1	f Yes, specify Cuba		Puerto Ricari, etc.)				1
ter der		3 Widowed		ed If Yes, Give Year			Yes 2X N		ind of work done		of Business/		
ours af	b b			only highest grade of		16a. Dece	dent's Usual Occup g most of working lif	fe. DO NOT u	use retired)	100.11		-	1
6 72 ho	ete	Elementary/Sec		College (1-4 o	or 5+)	Dis	abled			NA			
withir giene.	Completed	12th gi	e (First, Middle, La					18. Mother's	s Name (First, Middle	, Maiden Surn	ame)		
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Median	Be C	RichA			Red	ld		Pau	line ber or Rural Route N	umber City Of	Hig	e, Zip Code)	
212 ould by I Ment is mark	2		Name/Relationship							2-1+ima	MO M	14 212	18
MD d 2 sho lth and in 27 is			d Knights	s Aunt	20h F	Place of Dis	nosition (Name of	cemetery,	., AptB, I	20c. Loca	tion - City o	or Town, State	10
ore, slan of Hea If iter		20a. Method of D	Cremation	3 Removal from	State	crematory of	or other place)  mel Cem.		10-26-07	Dur	ndalk,	Md.	
Page ment or ot		4 Donation	5 Other Spec Funeral Service Li	cify:			22. Name and Addr	ess of Facilit					
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once.		4	_		Chen		1101 E.	North	Ave., Ba	ltimore	∍, Md.	21202 Approximat	
hysician	_	23a. Part I. Ente	r the disease, or co	omplications that cau	sed the death	. Do not er	ter the mode of dy	ng, such as c	ardiac or respiratory	arrest, snock,	ornean	Between O	nset and
<b>Nedical</b>		Immediate Caus	e (Final disease	a. Methadone	intoxic	ation	and narcoti	ic use					
≥xaminer		or condition res	ulting in death)	Due to (or as a c	consequence o	of):	_						
	er	Sequentially list if any, leading to	immediate	Due to (or as a c	consequence o	of):							
	Examiner	cause. Enter U (Disease or inju	nderlying Cause	c. Due to (or as a c	consequence of	of):							
ansit (4)	Ĕ	events resulting	in death) Last	d									
be executed sician and unial - transit	dical	X UNPEND	ED	AMENDED 2	7,28a-f,	perME,	3872, 10/29	/07 TT		234	Date of deliv	verv	
760, cate be physici	Med	IF FEMALE:	ent pregnant in the	23c. If yes, o	utcome of pre		Fetal death	_	oic pregnancy		onth	Day	Year
687 certific nding se as t	ian	past 12 mo	nths?		ant at time of d		Other (Specify)						l
cords, P.O. Box 68760 av requires that the death certificate the asserting physis as been signed by the attending physis carbonal be detached for use as the buy	Physician/Me	1 Yes 2		nown g Unkno			the underlying cal	use given in				e to the cause of	
P.O. I es that the igned by the detache	1 2		ignificant conditi	ons contributing to	death but not	resulting i	n the underlying cal	230 g. 10.1	1	Yes 2	No 3 F	Probably 4 🗸	Unknown
S, P.  Lires th  a signe  d be d	d ba	<u> </u>								Was an autopsy	24b. Were	e autopsy finding to completion o	gs available f cause of
ords w requas been	ala	<u> </u>								performed?	deat		
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death.  To the Funeral Director: The this funeral page 3 should be deached for use as the bit of the Lin Line Line Annal Aircetor near 3 should be deached for use as the bit.	Completed by	<u> </u>					26.	Place of Dea	th (Check only one)				
cian:	9	25. Was case examiner?	referred to medica	Hospital:	Inpatient 2	✓ ER/Out	patient 3 DOA	Other <sub>4</sub>	Nursing Home			Other:	
of Vil ing Physic After this	E   C	1 ✓ Yes 27. Manner of	2 No Death	28a. Date (Month			me of Injury 280	. Injury at W		ribe how injur	y occurred		
on Con Conding		1 Natura	5 Pend	ting Find 1	10/21/200	07 unk		Yes 2		tion (Street ar	nd Number (	or Rural Route N	lumber, City
r Atte	n oy u	2 Accide	e 6 X Cou				m, street, factory, o	ffice building	, etc. 281, 200a 1106	wn State) Milton A	ve. Ba	ltimore, l	MD
Division  Bospital or Attend 24 hours after death. Funeral Director:	Tilled in by the functar un	4 Homic	detedete		Found:			me date and	alone and due to the	cause(s) and	d manner as	s stated.	
Division  To the Hospital or Attent within 24 hours after death to the Funeral Director.			Certifying P  Medical Exa	miner:On the basis	of examinatio	n and/or in	vestigation, in my o	pinion, death	occurred at the time,				
To the within To the	comp	0 [	e and title of certifi	and mariner	stated.		29c.	License num	ber	29d. L	Jate signeu	(MOTHER, Day, 11	ear)
	1	1	11 h A	e Heo	e0a	N		O.C.M.E.		Octo	ober 22, 1		
		30. Name and	address of perso	n who completed cau	use of death (I	Item 23a)		altima a ==	MD 21201				
2		Carol A	llan, MD As	ssistant Medica	l Examiner	111	Penn Street, B	aitimore,	VID 2 1201				
	Sta	te 31. Date filed	(Month, Day, Year	Ma.	Registrar's Sig	nature	Bet						
Rec	jistr	ar (	CT 2 5 2	OCME		OP.	IGINAL						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** P. M 200 0 /Medical 4b. City 4c. County of Death acility Name (If not institution, give street and number) Town, or Location of Death 4a Examiner altimor If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 4 2 F Yrs Director None Oct 16, 2007 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 □ ¥es 2 □ No Director Randallstown Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9919 Shoshone Way 21133 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: <u>م</u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Item 27 is marker any injury or any inju Be Faheem Hammett Kenise Hammett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 9919 Shoshone Way Randallstown, Maryland 21133 Faheem Hammett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Murial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/20/07 Windsor Mill, Md. King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00875 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Cuar Approximate Interval Between Onset and Death 23a. Par 1. Ent. The disease, or complications Let / aused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on. Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No <sup>2</sup> □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Examiner be executed and Box 68760, attending physician the law requires that the death certificate as use for P.O. ed by the a signed to Division or Vital Records, page 2 should peen has The certificate Attending Physician: director this funeral After t death.

Show

Baltimore, Maryland 21215-0036

within 72

12 should be filed what and Mental Hygier is marked other the

To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

B

State Registrar

Medical

29a. Certifier

32. Registrar's Signature

and manner stated.

29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Belvedere Avenue Baltimore, mo

			1 - State Registrar  1. Decedent's Name (First, Middle, Last						ealth a <b>lhb</b> Death		2. Date of Dea	ath	~	34239
	Physici /Medio Examin	al	4a. Facility Name (If not institution, give	KODIN Mai	ctin	Johnst		Sr.	Location o		October		2007 County of Death	11:45 PM
	Examin	ier	Longreen Nursing 1				Bal	timor	æ			N,	/A	
Ì	Funeral Director			7. Age	(In yrs. 42	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day May 31,	n v, Year) 1965	Cot	nplace (State or Foreign untry) land
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	cation							10d. Inside City Limits
	Maryli f sho ied at	to	MD N/A		E	Baltimo	re							1XXYes 2 □ No
	with the 3a or 28a	I Director	10e. Street and Number 3807 Conduit Avenu	ie		-		ip Code 21211				_	en of What Co	untry?
15-0036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1  Yes XX If Yes, Give Year or Dates:		H	f Yes, sp	edent of His ecify Cubar 2	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
2-C	"natu	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of v	ork done d	urina mos	t of worki	ng j	16b. Kin	d of Business/I	ndustry
12	within iene. than the Me	Completed	Elementary/Secondary (0-12) 7th	College (1-4or 5	+)	Home L	Impr	oveme	ent			MJ (	Contrac	ting
Maryland 2	be filled ntal Hygi ed other event, t	To Be Co	17. Father's Name (First, Middle, Last)	Nelson J	ohns	ston					(First, Middle,		Surname)	
ar S	s 1 and 2 should f Health and Mel item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (T)	pe. Print)		1	_					-	Town, State, Z	(ip Code)
	and 2 ealth m 27		Dana Johnston (Wii	ie)	1001 5				e Dr		Balto,		21030	
nore	Pages 1 nent of H int: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ I		0	Place of Dispos cemetery, cren LTO Cres	natorý ol	other place		ا 10/19	) ate		cation - City or consvil	
Baltimore,	permit. Pages Department of Important: If II any Injury or once.		4 □ Donation → □ Other (Specify,			_ Bű	rgee		s of Facilit	řtz I	uneral	Home	e, Inc.	
1	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ica of that caused ne cause on each lin		h. Do not ente	er the m	ode of dying	g, such as	cardiac o		rrest,		Approximate Interval Between Onset and Death
8760,	/Medical Examiner  bhysician and sthe burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	consequence of C	uence of):			<b>Р</b>				100	2 months
9	tificate g phy as the	0		J					-1	âA	A SHOULD BY	MEDICAL	EXAMINER	
O. Box	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	aldeath 3□	Ectopic Other (	pregnancy specify)	CER	TIEICATIO	APPROVED BY	2	3d. Date of deli Month	ivery Day Year
J	w requires that been signed by should be deta	b	Part II. Other significant conditions co	ntributing to death bu	ut not res	ulting in the ur	nderlying	cause give	n in Part I		23e. Did to		se contribute to	the cause of death?
Hecords,		Completed									24a. Was autor perfo		24b. Were au prior to death? 1 □ Yes	stopsy findings available completion of cause of
Vital	Iclan: Sertific Sector,	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only o	ne)		
	Phys this cral dir	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		ER/Outpatien 28b. Time of			4 (A) N		me 5 Resident		Other (Spec	cify)
Division or	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide	(Month, Day 08/26/20 28e. Place of injubuilding, etc	/ Year) <b>07</b>	Injury Unknow	M	28c. Injury Work 1 ☐ Y ory, office		No	Unknow	<b>n</b> Street and	d Number or Ru	ıral Route Number,
ב	ital or irs aft rai Di lled in	Cer				Unk	DOWN				Unkno			
	e Hosp 24 hou e Funei letely fil	edical		siclan: To the best of Iner: On the basis of and manner sta	examina									
	To the To the compl	Me	29b. Signature and title of certifier					9c. License				29d. Date	signed (Mont	h, Day, Year)
	5		1 Di Cu	Salla	r. U	9	10	3/(3	6			0e	TOBER	18,2007
d De	(A)		30. Name and address of person who o	ccace W	eath (Iter	n 23a) (Type, 1	Print)	CLBI	2,00	R	BACT	-(Mol	iE, Wil	21236
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ature	6º 9				,			

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/giene	$\cap$	$\cap$	7	2	1.	2	1.	
Reg. No.	U	U	I	J	r‡	4	4	

R			1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	L per fh, g872	2,102	ertificate of	Death	2. Date of De	eath		3 4 2 l	
	Physici		Doris		Ja	mes		Oct.	10, Da	<sup>y</sup> 200 <i>7</i> <sup>ear</sup>	15:33	М
į	/Medio Examir		4a. Facility Name (If not institution, give st. Univ. of Mary		al C		or Location of Death	1	40	. County of Death	1	
	Funeral Director		<u> </u>	7. Age (In yrs. I	last birthda Yrs	Months Davs		8. Date of Bir (Month, Date 02/02/	ay, Year,	Cot	nplace (State or Fountry) ryland	oreign
	land ow it		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or	Location					10d. Inside City L	imits
	Mary a-f sh ified a	tor	MD	Bi	altim	ore					↑ Yes 2	□No
	th the or 28; e not	Sire	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Co	untry?	
	ath w	ral	265 S. Spring Cou		0 1.		1231			USA 14. Race - Amer	rican Indian	
030	be filed within 72 hours after death with the Maryland tla Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.5.	3. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☐ No		to Rican, etc.)	)-	Black, White	e, etc.	
215-0036	72 ho natur dical I	Completed	15. Decedent's Educa (Specify only highest grade	ation co <i>mpleted</i> )	16a. De	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of wo	rking	16b. k	(ind of Business/l	ndustry	
7	vithin ane. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		ice Care			Drx	Cleaner	ra	
Z D	filed v Hygie ther t	ပိ	12th 17. Father's Name (First, Middle, Last)		Serv	ice care	18. Mother's Nar	ne (First, Middle				
/iand	0 = 0 2	To Be	Moses M. James				Lilly	Flourn	ey			
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.	-	19a. Informant's Name/Relationship (Typ-	e. Print)	19b. M	ailing Address (Stree	t and Number or Ri	ural Route Numb	er, City	or Town, State, 2	ip Code)	
, Mar	and 2 ealth a n 27 ls		Cynthia A. James			09 Elkade	r Rd., Bal		MD	21218		
galtimore,	of He item		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	emoval from State	emetery, o	sposition (Name of crematory or other pla	1	Date		ocation - City or		
Ē	permit. Pages 'Department of Himportant: If ite any Injury or of once.		4 □ Donation 5 □ Other (Specify)	Gre	eenmo	unt Crema						
ga	Depar Mpor mpor nny In		21. Signature of Funeral Service Licenses			22. Name and Addr	timore Na			rvices,		122
	40= # 0	H	Vaughn C. Gree		h. Do not		_			, parti	Approximate Interval Betwe	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final						,		Interval Betwe Onset and Dea	en ath
	Physician /Medical		disease or condition resulting in death)	s/p Fall,	AICG	OHOT THE	OXICALI	J11				
	Examiner		1.	Due to (or as a consequence non-surviv	vabl	e brain	injury		O 8	Cake	30 hrs	
١,	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq	uence of):			0.0	W			
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Durate (annual part)				KA	MARKET	,		
ρΩ,	oe exi	Ē	resulting in death, East	Due to (or as a consequ	uence or):		( )	FED BY MEDICAN E				
68/60,	cate t	ledical	d.				OX - 100	ED BY				
	certific ding p		IF FEMALE: 23	3c. If yes, outcome pf pregna		-	NO STATE OF THE PARTY OF THE PA			23d. Date of del	ivery	
.C. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		3 ☐ Ectopic pregnan 5 ☐ Other (specify)	e di di			Month	Day Yea	ar
λ, J	es that gned b	by P	Part II. Other significant conditions conf		ulting in th	e underlying cause g	iven in Part I.				the cause of dea	
g	equire en sig	led I	- Gastiic cance	-				1	Yes :	2 No 3 Pi	robably 4XJUnl	known
vital Records	The lay ate has page 2	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Was auto peri 1 Yes	opsy formed?	prior to death?	utopsy findings ava completion of cause	ailable se of
VII.	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			thor	ath (Check only				
0	Phy r this	.T	1 X Yes 2 No no 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpa 28b. Tim	illerit 3 DOA	4 □ Nursing i	-lome 5 XRes 28d. Describe		6 □Other (Spe	cify)	
	ng interior	Certification:	1 □ Natural 5 □ Pending 2 ☒ Accident investigation	10/9/07	6:00	ry 7	ork? □Yes 2≹No	Alcoho	_	Fall		
DIVISION	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specification)			e	28f. Location	(Street a	and Number or Ri	ural Route Numbe	∋ <i>r</i> ,
5	s afte al Dir ed in	Cert	4 [] Torniolde	Home	197			265 S	S . S	ğring <sub>3</sub>	ural Route Number Court	
	he Hospital or Attendi nr 24 hours after death. he Funeral Director: A pletely filled in by the fu	Medical (		Ician: To the best of my kno ner: On the basis of examina and manner stated.				e, and due to the	e cause	of and manner as	a stated.	
)	To the le within 2. To the I complete	Ž	29b. Signature and title of certifier	Sh.		29c. Licer P 2 2	nse number 240		29d. D Oc1	ate signed (Mont	h, Day, Year) 2007	
			30 Name and address of person who con Dr. Danielle Da	npleted cause of death (Item	" GP Gy	ene St,	Baltimo	re, Md	212	201		
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 5 2007	32. Registrar's Signa	ature	de la						

DHMH 17 Rev 1/2001

For State Registrar

et.	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month OCNBER	Day 2 Year 2 21.39 M
4	/Medic	al	4. Salika Nama (If and institution give attent and sumbar)	4b. City, Town, or Location of Death	4c. County of Death
	Examin	er	SINMTWOSPINAZ OF BANMI	ORE BALTIMORE CITY	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 7 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		
	arylan show	r	11/1	ra Hmore	10d. Inside City Limits 1 XYes 2 □ No
	the M 28a-f notifie	recto	10e. Street and Number		0g. Citizen of What Country?
	th with 23a or 1st be	Funeral Director	2327 Ashburton Street	21216	USA
	ter dea	nue	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 MNo Specify:	Specify: Black
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Social Security
212	within jiene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk	Administration
pu	be filed tal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, I	
ryla	should be ind Mental marked of umatic ev	2	trnest mugnes	19b. Mailing Address (Street and Number or Rural Route Number	
Ma	1 and 2 sho Health and em 27 is ma		Boverly Thompson/Daughter		Wilmore MD 21207
Baltimore,	a - = =		20a. Method of Disposition 20b. Place 1 M. Rurial 2 Committee 3 Department 2 Depart	ce of Disposition (Name of Date metery, crematory or other place)	20c. Location - City or Town, State
I iii	+ 두 후 후		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	22. Name and Address of Facility January	Woodlawn MD
Ba	Depai Impoi any Ir		> Vaughn C. Stee	8728 Liberry Road Kana	Greene Funeral Sycs 1911 Stown MD 21133
			23a. Part1. Enter the disease, or complications that caused the death. shock, on lead failure. List only one cause on each line.	Do not enter the mode of dying, and as cardiac or respiratory arr	
	Physician		Immediate Cause (Final disease or condition resulting in death)	BRATIN INJURY	5 DAYS
	/Medical Examiner		Due to (or as a conseque	ince of):	
	D H	iner	Sequentially list conditions, if any, Isaam to immediate cause. Enter Underlying	nos off:	
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque	ence of):	
68760,	e be e ysician e buria				
	- D 6	cian/Medical	IF FEMALE:		
Вох	eath cert attending for use	cian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnant 1 Live birth 2 Fetal c	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
P.O.	res that the de signed by the be detached	Physi	1	1	the shall be said to the shall be
	ires the signed I be de	þ	CHRONIC OBSTRUCTUE	DILLINAKLOY MILAGE	bacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Nonown
or Vital Records,	w require been sign	Completed	PNEUMONIA	24a. Was a	an 24b. Were autopsy findings available
Re	The lav	omb		autop perfoi 1	sy prior to completion of cause of death? 2 № No 1 □ Yes 2 № No
Vita	Physician: The rhis certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of	
o	Phys this ral di	: To	To Tes 25 No	28b. Time of 28c. Injury at 28d. Describe h	dence 6 LOther (Specify)  now injury occurred
sion	Attending Pher death. ector: After the by the funeral	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	M 1 Yes 2 No	
Division	l or Att after de Directu	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At hom building, etc. (Specify)		Street and Number or Rural Route Number, vn, State)
ы	spital nours a neral I			vledge, death occurred at the time, date and place, and due to the	cause(s) and manner as stated.
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical		on and/or investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	Vitt Con	Σ	29b. Signature and title of certifier		
	7		30. Name andyaddress of person who completed cause of death (item)	23a) (Type, Print)	OCTOBER 17 2007 PITA OF BANTHORE
1	0		MYA MARIA ORB		PIND OF BATTHORE
	St	ate	31. Date filed (Month, Day Year) 32. Februaria's Signatu	JIG TO THE TOTAL	

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007

Certificate of Death

34241

State of Maryland / Department of Health and Mental Hygiene 0 0 7 34242 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** AM 7007 1.56 MONICA 10 "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner BOUTIMORE KANDAUSTONA NORTH NYST HOSPITOI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Yrs. 41 MARYLAND Director 216-78-1000 APR. 3 1966 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at Show 1XXYes 2 No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 4124 MARIBAN COURT U.S.A. 21225 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental JEROME JOHNSON SR. EILEEN JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3642 Grand Blvd, Brookfield, Beatrice Lewis/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or of once. 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10-25=07 LANSDOWNE, MARYLAND ZION CEMETERY 22. Name and Address of Facility
WILLIAM C BROWN COMM
1206 W NORTH AVENUE of Funeral Service License COMMUNITY FUNERAL HOME P.A. Jasbara Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HITOSTOTIC CONCINOID Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ō Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 MIInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMOCOCCK BOCTERENIA 1 Yes 2 No 3 Probably 4 Unknown 1094T4S MALLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy perform RENDL FAILURS certificate 2 No Division or Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mapher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i Director; of in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRT KINO 21133 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

5 2007

ORIGINAL

			1 - State of Mai	yland / Depa <i>Cer</i>	artment of Heal ctificate of Dea	ith and Me a <i>th</i>	ental Hygie Reg	ene 2007	34244
i	Physici		Decedent's Name (First, Middle, Last)     Evelyn Mae Long				2. Date of Death Month 10	Day Year 21 200	3. Time of Death 7 9:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  117 Bliss Lane		4b. City, Town, or Loca		-10	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)			B. Date of Birth (Month, Day, Y	Anne A	thplace (State or Foreign
~	Director		216-22-5166	86 Yrs.			(Month, Day, ) 12/17/1	920	MD MD
	Marylan f show ed at	or	10a. State 10b. County MD Anne Arunde1	10c. City, Town or Lo Glen I					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	or 28a-	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What C	ountry?
	ms 23a ms 23a	Funeral	117 Bliss Lane  11. Marital Status   12. Was Decedent Ex	rer in U.S. 13. \	21060 Was Decedent of Hispan f Yes, specify Cuban, Me	ic Origin? (Spec	ify Yes or No-	USA 14. Race - Ame	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2			exican, Puerto R ec <i>ify:</i>	ican, etc.)	Black, Whi	<sub>vhite</sub>
215-0036	72 hou 'natura olcal E	eted l	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	g 16	Bb. Kind of Business	/Industry
רצרצ	d within giene. rr than ' the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ity Control			Factory	
and	d be filed antal Hyged others; event,	Be	17. Father's Name (First, Middle, Last) William Hertz	1 7	18. !		(First, Middle, Ma	uiden Surname)	
Maryland	2 should and Me Is mark aumatic	으	19a. Informant's Name/Relationship (Type. Print)	T.	g Address (Street and N	lumber or Rural	Route Number, (		Zip Code)
2	Health tem 27 other tr		Mrs Bonnie Brown/daughter  20a. Method of Disposition	20b. Place of Dispos	Bliss Lane,	Glen Bu		21060 Oc. Location - City or	Town, State
Baitimore,	Pages ment of ant: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Glen Have	natory or other place) n Cemetery	10/25	/2007	Glen Burn	nie MD
gal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		21. Sign, ure Funeral Style LT Ansee	2001001	Name and Address of F 2nd Ave SW	Sing		neral & 0	Cremation Srvc
~ A.	<b>*</b>		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do not ente	er the mode of dying, suc	_			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a	consequence of):	uncer				3 years
	Examiner	er	Sequentially list conditions, if any, leading to immediate Due to (or as a	consequence of):					
P	ecuted and transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
g/pn,	icate be executed physician and s the burial-transit	dical E	d.	consequence of):					
0	certifica Iding phi Ise as th	/Medi	IF FEMALE: 23c. If yes, outcome pt	pregnancy				22d Data of da	livan
J. BOX	w requires that the death certifit been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months?  1 Yes 2 No 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
7.	requires that the een signed by th hould be detache	by Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in I	Part I.	23e. Did toba	cco use contribute t	o the cause of death?
cords	requires seen sig hould be						1 ☐ Yes	2 <b>₫</b> № 3□P	robably 4 Unknown
Ž	The law ate has b bage 2 sh	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Other		(Check only one)		
_	<b>6</b> 6 <b>0</b>	on: To	27. Manner of Death  1 Death  1 Death  1 Death  1 Month, Day 1	28b. Time of	1 3LJ DOA   41		e 5 Residen 3d. Describe how	ce 6 Other (Spe injury occurred	ecify)
VISION	Attending r death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury	- At home, farm, stre	M 1 ☐ Yes eet, factory, office		Bf. Location (Stre	et and Number or R	ural Route Number,
5	pltal or urs afte eral Dir		4 ☐ Homicide determined building, etc.  29a. Certifier 1 ★ Certifying Physician: To the best of		and the state of		City or Town,		
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check only one) 2 ☐ <b>Medical Examiner:</b> On the basis of each manner state	xamination and/or inv	estigation, in my opinior	n, death occurre	d at the time, dat	e and place, and du	e to the cause(s)
	To To 1	2	29b. Signature and title of certifier P Jonny.	NO	29c. License num		290	Date signed (Mon	th, Day, Year)
	6		30. Name and address of person who completed cause of dea			- 1	(1 12	1 1/2	0 = 1=1
	9 Sta		JONE HUN P. FORMAN MD 1 31. Date filed (Month, Day, Year) 32 degistrar	s Signature	NTIENTEN FIX	>1e/t (	) len Du	vnie Mi	1 21001
	Registr	ar	OCT 2 5 2007	, It has	Section 1				

		1	State	partment of Health and Neartificate of Death	Mental Hygiene Reg. №	
6			1 December Name / First Middle   2st)		2. Date of Death Month Da	3. Time of Death
	sicia edica	al .		UGE	10 09	- 950 1 6.71 L W
	mine		4a. Facility Name (If not institution, give street and number)  ADD SECOUNS HOTPITAL	4b, City, Town, or Location of Death	71223	: County of Death
Fune			5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Year) 10/18/192	9. Birthplace (State or Foreign Country)     Maryland
Direc	tor	-	212-26-8279 77 Tis		10/10/102	10d. Inside City Limits
lanylan			10a. State 10b. County 10c. City, Town o	ore City		1  Yes 2 No
the M 28a-f	ocenii o	Director	MD Baltim  10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
h with	2		2117 Dennison Street	21216	Un	ited States
r deat	1	ner		<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Individed the Maryland 2 should be filed with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "netural, or Items 23s or 28s-f show		by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNO If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
72 hou	100		15. Decedent's Education 16a. U. (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of wor te. DO NOT use retired)		Kind of Business/Industry
within ne.	e Mag	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home
filed y Hygie	ant, III		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide	
uld be Mental	tic •	To Be	Wade H. Wisnom		a Burton	
2 sho	raum			Mailing Address (Street and Number or Ru Third Street, Rehob		
1 and 1 and Health 18m 27	ther t		20a Mathod of Disposition 20b. Place of D	isposition (Name of		ocation - City or Town, State
Pages nent of ant: If it	ry or c			v Crematory or other place)	4/2007 Bal	timore, Maryland
paritimore, intaly failed ATLID-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-1 show	eny inju once.		21. Signature of Fundral Service Licensee M01113	22. Name and Address of Facility 2729 Hudson Stree	Skarda Fun t. Baltimor	
			23a. Part1. Enter the diseasel or complications that caused the death. Do not shock, or heart ailure. List only one cause on each line.			Approximate Interval Between
Physic			Immediate Cause (Final disease or condition	18 A		Onset and Death
/Medi Exami			resulting in death)  Due to (or as a consequence of)	:		
A	5	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:		
rcuted	transit	Examiner	triat intriated events			
<b>6/60,</b> ate be exemply sicien a	burial-	a Ex	resulting in death) Last Due to (or as a consequence of)			
Geath certificate be executed attending physicien and	as the	edical	d			
BOX auth cert	esn J	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
. 0 0	thed fo	Physician/Me	in the past 12 months?  1	5 Other (specify)		
ords, P.O. requires that the sen signed by th	e detac	by Ph	Part II. Other significent conditions contributing to death but not resulting in t	he underlying cause given in Part I.		use contribute to the cause of death?
ords equire en sig	q pino	ted b	HUPERTENSION		1 🗆 Yes	2 No 3 Probably 4 Nunknown
law ra	9.2 sh	Completed	H400 TH4 R010		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VICAL RECORD  sicien: The law requir certificate has been si	r, page 2	e Cor	SCHIZO PHRENIA	26 Place of De	performed?  1 Yes 2 N  ath (Check only one)	lo 1 Yes 2 No
yalcien yalcien s certi	director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: ☑ Inpatient 2 ☐ ER/Outp	Other	dome 5 Residence	6 ☐ Other (Specify)
DIVISION OT I or Attending Phys after death. Director: After this	meral		27. Manner of Death 1★Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inj	ury Work?	28d. Describe how in	jury occurred
ISIO ttendi death. stor: A	the fu	icatl	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
DIVI I or A	d in by	Certification:	4 Homicide determined building, etc. (Specify)	n, strast, lactory, onless	City or Town, Sta	
UNISION OT VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific	tely fille	edical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and plac for investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
o the o the	отрів	Med	COb. Simplify and title of partition	29c. License number	l l	Date signed (Month, Day, Year)
FBF	ō		I mot 11- knowbeh, mo	0149 49	/	10/02/2007
10			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print) 2000 W BA.	MATIN	271EET
W	, O		31 Data tilad (Month Day Year) 32 Hindstrat's Signature		100 0100	7
Re	Sta aistr		OCT 2 5 2007	Social D		

DHMH 17 Rev 1/2001

			State of Maryland / Dep	ertificate of D		, ,	ene a. No 2007	34246
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodio oi D	- J	2. Date of Deatl		3. Time of Death
	Physicia		Ruth Elizabeth Mitchell			Month 10	Day Year 2007	9:43 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	Location of Death		4c. County of Deal	
ė	Examin	eı.	Casey House	Rockville	<b>e</b>		Montgome	rv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Birl	hplace (State or Foreign
	Director		579-10-0856 1□M 2₩F 87 Yrs.	World's Days	Hours Will.	11/17/	1919 Was	hington D.C.
	pu ,		Usual Residence of Decedent	ocation				10d. Inside City Limits
	anylar shov	_	,					1 ☐ Yes 2 ☐ No
	he M	Director		ry Village		1/	Og. Citizen of What Co	Λ
	with t a or 2 be n	ä	10e. Street and Number	10f. Zip Code			U.S.A.	ountry:
	s 23	Funeral	19301 Watkins Mill Road  11 Marital Status   12 Was Decedent Ever in U.S.   13	20886	spanic Origin? (Spe		14. Race - Ame	rican Indian,
_	ter d	Ē	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 √2 No	. Was Decedent of His If Yes, specify Cuban	n, Mexican, Puerto I	Rican, etc.)	Black, Whit	
2000	urs af	by I	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give A Year or Dates:	1 ☐ Yes 2☐ No	Specify:		Specify: Wh	ite
5	2 hou		15. Decedent's Education 16a. Dec	edent's Usual Occupat	tion		16b. Kind of Business	
7	hin 7 an "n Medi	ed	(Specify only highest grade completed) (Giver life.)  Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done du DO NOT use retired)	uring most or workii	,g		
7	gien vit	Completed	12 Hous	ewife			Home	
2	be file	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Name	,	'	
<u>8</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	은	Otto Martin William Neilson		Ruth Eloi			
<u>0</u>	2 sh and Is m			iling Address (Street a				
1) 1)	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Healin and Mental Hygiene.  If of Healin and Mental Hygiene, "natural", or Items 23a or 28a-f show the firem 271s marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Janet Ward/Daughter Lake  20a. Method of Disposition 20b. Place of Disp	Landing R			20c. Location - City or	
2	Pages nent of h ant: If ite ury or of		1 ☐ Burial 2 ☑ 1 © remation 3 ☐ Removal from State cemetery, cr	rematory or other place	9)			
Dallimor	it. Partmen			atory 22. Name and Address	10/19/		linton, MI	
0	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.			633 01d A1	Lee	Funera		. MD 20735
-			23a. Part1. Enter the rispase or complications that caused the death. Do not e					Approximate
	Dhuaisian		shock, or heart failure. List only one cause on each line.					Interval Between Onset and Death
	Physician /Medical		resulting in death)  a. Pneumonia  Due to (or as a consequence of):					
	Examiner							
h		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events					
Ď,	e exe ian ar irial-t		resulting in death) Last Due to (or as a consequence of):					
0/00,	death certificate be executed e attending physician and id for use as the burial-transit	dical	d					
Ď ×	w requires that the death certific been signed by the attending p should be detached for use as	Mec	IF FEMALE:					
X D D	ath c	Physician/Me		B Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown 5	Uther (specify)				
7.	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	n in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?
S.	sign d be	d by				1 □ Ye	es 2 No 3 P	robably 4 🔀 Unknown
ecords	v req been shou	ete				24a. Was a	n 24b. Were a	utopsy findings available
Ď L	he law e has b ige 2 sh	Completed				autops perforr	med? prior to death?	completion of cause of
VIII	ificate or, pa		25. Was case referred to medical		26. Place of Death		2 <b>)</b> No 1 ☐ Ye	s 2 No
>	/sicia	o Be	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ient 3 DOA Othe	r.		ence 6 XOther (Spe	Hospice
5	g Phy er thi eral (	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury			ow injury occurred	
VISION	ath. nr: Aff	atio	2 Accident investigation		res 2 □No			
<u> </u>	er der recto	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	tural Route Number,
5	Ital on the after all Died in	Certification:						
	To the Hospital or Attending Physician: The law within 24 butus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or					
	the Prin 24	ledi	one) and manner stated.	200 Linenes	numbor		Od Data signed (Man	th Day Yearl
	with Cor	Σ	29b. Signature and title of certifier who believes to 1 m.	29c. License		2	9d. Date signed (Mon	
) .	1		189 101	D_0064		1 - 1 :	10/18/200	07
Ĺ	† '		30. Name and address of person who completed cause of death (Item 23a) (Typ		ieve Wrob	1ewsk1		
	Sta	to	13 <sup>5</sup> 5 Piccard Dr. Suite 100 Rockville 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, MD 20000				
	Sta Registr		00T 0 E 2007	Courses				

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		,,	Cert	ificate of	Death	1	Reg. No. 2007	34247
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	-				2. Date of Dea	ath Day Year	3. Time of Death
	/Medi	cal 🍦	LUTENE Mars  4a. Facility Name (If not institution, g	hall			4h City Town o	r Location of Death	UCTOBE	1 20 200 4c. County of Dea	
	Examir	ier	Saint Agnes	11 011	/		Balti			lo. county of Box	att
ls.	Funeral Director		5. Social Security Number 6. 213-32-4060 Usual Residence of Decedent	Sex 1 □ M 2 F 7. Age	(In yrs. last b		If Under 1 Year Months Days		8. Date of Birt (Month, Da May 0	9. Bi y, Year) 1, 1935 Ba	rthplace (State or Foreign country) Himarc, MD
	yland now at		10a. State 10b. County		10c. City, Tov	vn or Loca	ation				10d. Inside City Limits
	e Mar 3a-f sh tified	Director	MD		P	auti	more				1 Yes 2 No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	leath ins 23smust	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.	13. W		216 Ispanic Origin? (Spec	cify Yes or No-	USA 14. Race - Am	erican Indian,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	þ	1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ N  If Yes, Give  Year or Dates:			Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	Rican, etc.)	Specify:	ite, etc. a C K
5-0	"natu	letec	15. Decedent's l (Specify only highest g	Education rade completed)	168	(Give k	ent's Usual Occup	oation during most of workin d)	g	16b. Kind of Business	s/Industry
121	withir iene. • than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	7	ietary	2)		Health Cal	ce
Jd 2	e filed at Hyg other vent, t	8	17. Father's Name (First, Middle, Las	it)			1	18. Mother's Name	(First, Middle,		
ylar	ould b Menta arked	70 E	Bernie Johnson					Mary Wa	Shing	ton	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship	1.	ughka //	b. Mailing	Address (Street	and Number or Rural	Route Number	er, City or Town, State,	Zip Code)
ē,	es 1 and 3 of Health fitem 27 rother tra	- 4	20a. Method of Disposition		20b. Place of	of Disposi	tion (Name of atory or other place	Da STILLET.	ate Tate	more mD 20c. Location - City o	r Town, State
iii O	Pages nent of t ant: If ite		1 Burial 2 □Cremation 3 4 □Donation 5 □ Other (Spec		Garri	.,,	and y or ourser prac	1			
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	ensae	190	22. 51	Name and Addre	ss of Facility Vouc	Inn C. G	Owings Mi reeni gunera Bultimon	MD 21224
8			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death. Do	not enter	the mode of dyir	ng, such as cardiac or	respiratory ar	rest,	Approximate Interval Between
الم	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pan	creation	Ca	ncer				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):					
	E.	Jer	Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or injury	b Due to (or as a	a consequence	of):					
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
68760,	rtificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a	a consequence	of):					
			IF FEMALE:								
.O. Box	law requires that the death ce as been signed by the attendir 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 🗌 Fetal deat		Ectopic pregnancy Other <i>(specify)</i>			23d. Date of de Month	elivery Day Year
%, P	ss that gned b		Part II. Other significant conditions						23e. Did to	bacco use contribute	to the cause of death?
ord	require sen siç nould b	ted t	Whipple Proce Disease, Coro	aure; Hy	perfer	ISIVE	Cardw	rascinlar	1 🗆 \	/es 2 <b>Д</b> № 3 Б	Probably 4 □Unknown
LUrune al Records, P.	The lar ate has page 2	Completed by	<u></u>	nary HTR	ery Di	seas	(		24a. Was autop perfo 1□ Yes	an 24b. Were a prior to death?	
<u>}</u>	slclan: Th certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 - 2		3□ DOA Oth	26. Place of Death			
100	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injun (Month, Day		Time of	28c. Injur Work	4   Nulsing Flori		dence 6 Other (Sponow injury occurred	ecify)
Sion	ending Feath. or: After	atio	1 Matural 5 Pending 2 Accident investigation	on	rear)	Injury		Yes 2 □ No			
Ma Divis	ne Hospital or Attending Physician: n.24 hours after death. Ne Funeral Director: After this certifical pletely filled in by the funeral director, in	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	building, etc.	. (Specify)				City or Tow		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 ☐ Medical Exa	hysiclan: To the best of aminer: On the basis of and manner state	examination a	e, death on nd/or inve	estigation, in my c	pinion, death occurre	nd due to the od at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	with To 1	Σ	29b. Signature and title of certifier	X 11			29c. Licens	e number		29d. Date signed (Mon	
	1	-	30. Name and address of person who	of completed cause of de		(Type P	(rint)	CDB	(	October 2	0,2007
4	· · · ·	••	Gerard De Ca.  31. Date filed (Month, Day, Year)	stro, M.D.	900	Cato	n Avenu	ne, Balh	more.	MD 2122	9
	Sta Registr		QCT 2 5	2007	r's Signature		self 5				

Please Type or Print in Black Indended III. 2007 And Wiental Hygiene amend it state 7 Men Plans / PSE parting 17 Hearth and Wiental Hygiene Cortificate of Death Reg. No. 2007 34248 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MONTGOMERY 7:55PM 07 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. Lity, Town, or Location of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. (In vrs. last birthday) Social Security Number Date of Birth 1927 Birthplace (State or Foreign Country) Funeral 1□M 2**X**F Months 244.40.6131 79 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Baltimore MD 1 ☐Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2206 Roslyn 21216 Avenue US.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 10 of Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Privato 17. Father's Name (First, Middle, Last) Domestio 18. Mother's Name (First, Middle, Maiden Surname) Levi Blackmon Mamie) Cureton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Wesley Montgomeny Bautimore MD 21216 /HWband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Owingo Mills, MD Garnson Forest 29 107 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Furgeral Sent ices 8728 Liberty Road Randallstown MD 21133 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, up as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Whiknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 1 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Universing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Sertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 36942

Sta

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygien Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 Year Physician Octobes В (1):11:am ORRISON ,200 19 /Medical 4a. Facility Name (If not institution, give street and number) C.W. Routeway, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Bon Secour BALTIMORE Baltimire 21223 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 240-52-6243 1 XM 2 ☐ F 71 Yrs Director 1935 N. CAROLINA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show Ite Medicul Evandrar must be notified at MD HARFORD 1 ☐Yes 2 ☐ No ABERDEEN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 GUNNISON DRIVE 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ ♠ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specity: BLACK Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene important: if item 27 is marked other than "ns any injury or other traumatic event, if a Medis once. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION WORKER CONSTRUCTION 10TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HOMER B. MILLER ELIZABETH SANDERS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY M. COPELAND/ DAUGHTER 21 GUNNISON DR., ABERDEEN, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/27/07 WINDSOR MILL, KING MEM. PARK 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Enter the disease, or complications that caused the death. Do Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) 12710 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and e burial-transit be executed dias Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ressin phys. igned by the attending be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Ulnknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ▼No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Leetx 1 ☐ Yes 2 No 1 Yes 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 017 Tan son who completed cause of death (Item 23a) (Type, Print) Radimore 2000 (1) PMKOW N 31. Date filed (Month, Day, Year) OCT 2 5 2007 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

2007 34250

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	uneral		5. Social Security N	umber	6. Sex	7. Age (In yrs.	last birthday)		er 1 Year	+	4Hrs. 8.	Date of Birt	h (MM/DD/YYY	Y) 9. Birt Foreig	thplace (State or puerto
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n	,	ł	30. Name and addre	ss of person	who completed cau	se of death (Iter	n 23a)	وسنه					L		
U			Patricia Aror		k MD. Assist	ant Medical	Examiner	111 P	enn Str	eet, Baltii	more, N	/ID 2120	1		
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland obspartment of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relationship (Type, F Krystle Cooley / Fia	·			Street; Balt		1
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Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	Medical	one) 2 Medical Examiner: Or an	the basis of examination and manner stated.	d/or investigation, i	n my opinion, death 29c. License numb			ed (Month, Day. Year)
->-	Ž	29b. Signature and title of certifier	MODAIN		O.C.M.E.	o.	October 16	
		Caral A	uplated cause of death (Item)	23a)	3.0			
1		30. Name and address of person who com Carol Allan, MD Assistant	Medical Examiner	111 Penn Stre	et, Baltimore, M	ND 21201		
1	State	31. Date filed (Month, Day, Year)	32/ Registrar's Signatur	e A s				
Regi		OCT 2 5 2007	Destan D	LM315	<i>y</i>			

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07-08134 David L Meade Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David L Meade		- For State	Sta	ite of Maryla		artment ertificate			Ment	aı Hygı		2 0	07 3	3425
Physician Medical Examine	Î.	1. Decedent's Name David		,Last) eade							Date of Death Month October 18	Day Year	3. Time of E 1715 h	
	4	4a. Facility Name (i Cumberland		_	ımber)			Town, or L berland	ocation of	Death		4c. County of De Allegany	ath	
Funeral Director		5. Social Security N 215–58–7		6. Sex	7. Age (In yrs.		If Und Month	er 1 Year	If Under Hours	1	04/26	For	Birthplace (State eign Country) Mar	
, in	<u> </u>	Usual Residence o 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside	City Limits
and Show a	<u>.</u>	MD	Al.	legany		C	umber	land						2 X No
e Maryl or 28a-f	Director	10e. Street and Nu		reet			10f. Zip	Code 21502	)		10	g. Citizen of What C United S	•	
h with th		11. Marital Status		12. Was De	cedent Ever in U			ent of His	anic Origi		fy Yes or No-		erican Indian, E	Black,
ter deatl	키	1 X Never Marri		1 Yes	2 X No		Yes 2				an, otor,		lack	
hours af natural Examin	ea b		ducation (Spec	or Dates: ify only highest gra	de completed)	16a. Dece	dent's Usual g most of wo	Occupati	on (Give k			16b. Kind of Busine		
036 ithin 72 me. r thau "	Completed	Elementary/Seco	ondary (0-12)	College (	1-4 or 5+)		Labor	er				Casu	al	
e filed we filed we filed we filed we filed we ceed other fire.	2 8 8	17. Father's Name unk	(First, Middle,	Last)						,	irst, Middle, M Meade	faiden Surname)		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner, must be notified at once.	라	19a. Informant's Na Eric Mea						,	and Num	ber or Rura	al Route Num	ber, City or Town, Si		
e, MI Land 2: Health 8 Health 8	-	20a. Method of Dis	position			Place of Dis	position (Na	me of cen			Date	20c. Location - City		
Baltimore, permit. Pages I ar Department of He Important: If ite Important: If ite Injury or other tr		4 Donationy 5	X Cremation Other Sp	ecify:		Cedar H	Iill					Hartford		
Balf permit Depart Impor	+	21. Signature of Eu	ineral Service	Licensee MA	M01113	9	2. Name and 94 Gan	by St	of Facility creet	, Blo	iqua Fi comfiel	meral Ser Id, CT, 06	vices 002	
Physician /Medical			ne disease, or ally one cause	on each line.				of dying,	such as ca	ardiac or re	espiratory arre	est, shock, or heart	Between	ate Interval Onset and eath
xaminer		Immediate Cause or condition resulti		a. Hypertens  Due to (or as	a consequence		sease							
	Je.	Sequentially list of if any, leading to in	nmediate	Due to (or as	a consequence	of):								
- t	티	cause. Enter Unde (Disease or injury) events resulting in	that initiated	Due to (or as	a consequence	of):								
execu an and al - tra	Medical E	UNPENDED	)	dAMENDED										
760, ficate be g physici the buri	/Med	IF FEMALE: 23b. Was decedent	pregnant in th		outcome of pre		F-1-1-1		Estonic	pregnanc		23d. Date of deli	very Day	Year
Box 6876 he death certificate the attending phy hed for use as the	sicial	past 12 month	s?	4 Preg	nant at time of	death 5	Fetal death Other (Sp		EC(OPIC	pregnanc	.у	World	Day	T Gai
O. Bo at the de d by the tached f	ᆰ	Part II. Other sign		9 UIKI		t resulting in t	he underlyir	ng cause g	iven in Pa	ırt I.	23e. Did to	obacco use contribut	to the cause of	of death?
ords, P.O.	ted by	Recent his	story of pne	umonia							1 Yes	an 24b Wer	Probably 4	
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ital Rec sician: The s certificate irector, page	Be C	25. Was case refe examiner?	rred to medica					26.Place		(Check onl	ly one)			
of Viting Physic	위	1 ✓ Yes 27. Manner of Dea	2 No	Hospital: 1	Inpatient 2	✓ ER/Outpat 28b. Time		DOA 28c. Inju	Other <sub>4</sub>	Nursing I		Residence 6 Chow injury occurred	ther:	
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8 T E 2	ical	29a. Certifier 1	Certifying Pl	nysician: To the be	est of my knowle	edge, death o	ccurred at th	ne time, da ny opinior	ate and pla	ace, and du	ue to the caus	se(s) and manner as and place, and due	stated.	
To t with To t	Medical	29b. Signature and		and mariner	stated.			9c. Licens				29d. Date signed		ear)
		Dam		Dinut,	MID.	- 00		O.C.	M.E.			October 19, 2	007	
10		30. Name and add Donna M. \		who completed car D Assistant	medical Example 1		111 Penr	Street	, Baltim	ore, MD	21201			
Sta Registr		31. Date filed (Mor	nth, Day, Year)	150	Registrar's Sign	ature	whe							

DHMH 17 Rev 1/2001

DCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20071 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JOHN NASH Octoben 22 2007 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea BALTIMENE RANDAIISTENA CENTER PICAL NORTHWEST Date of Birth (Month, Day, Year) DV. 26, 1944 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 XM 2 □ F 62 Pennsylvania 218-44-9514 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 1221 White Mills Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specif White 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Computer specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Knapp James B. Nash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 White Mills Road; Catonsville, MD 21228 Elizabeth R. Nash (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 10/26/07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses semmer Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULLIPLE SCLEROSIS INACT INFECTION 1 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 25. Was case referred to medical examiner? DitBI 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Impatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** The law requires that the death certificate be executed and

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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has

After this certificate

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filled in by

or Attending Physician:

death.

hours after death uneral Director:

within 24 hours a

Division or Vital Records, P.O. Box 68760.

Examine

Physician/Medical

Completed by

Be

Certification: To

23b. Was decedent pregnant

determined

27. Mann of Death 1 Matural 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO CONGNAN res 13 2. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) OCT 2 5 2007

Amend #13&14 Per FH G873 11/07/07 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Amend #25, perMD, C872.10/25/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DANIEL, NEYRA Day 3 **Physician** DANTE, 22:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** UNIVERSITY OF MAKYLAND BALTIMORE 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days 216-53-4486 26 August 29, 1981 Peru Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Columbia Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21045 U.S.A. 5750 Flagflower Place Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Peruvian Baltimore, Maryland 21215-0036 Specify: Peruvian ò 3 Widowed 4 Divorced hut i Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mex Elementary/Secondary (0-12) College (1-4or 5+) Auomobile Sales Associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Teresa Yong Luis Neyra ပ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 Is any Injury or other trau 5750 Flagflower Place Columbia, Maryland 21045 Ms. Benita Daniel Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10/19/07 Laurel, Maryland MD National Cemetery 4 Donation 5 Dother (Specify) 21. Sign Jure of Funeral S 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respij, tory a rest, e. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) BRAIN INJURY TRAUMATIC **Physician** /Medical Due to (or as a consequence of): Examiner HARTHER MON LE PROTETO BY HEATEN LE THEN THE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2MNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a Was an page 2 autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes -25€ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Pay 1 Natural SELF INFLICTED GUNSHOT 2 Accident Place of injury - At building, etc. (Spe 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide At home, farm, street, factory, office 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature ar ho completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 OCT Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SAMENDI MARMANO / Department of Aleath and Wental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 11:00 AM Price Zelma 200 00 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ouch of Class Assistant living ltimore If Under 1 Date of Birth (Month, Day) 7. Age (În yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 K F Months 8 **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1XYes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social erb 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2512 Madison Ave. Chartruse hobinson/Niece Baltimore MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition

1 Method of Disposition

1 Method of Disposition

2 □ Cremation 3 □ R

4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 22. Name and Address of Facility Vaughn C. Green where Service 21. Signature of Funeral Service Licensee Baltimore National Pilhe, Baltimore mo 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Vatural Physician ause Years /Medical Due to (or as a consequence of): Examiner rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mass Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed history pulmonary embol Division or Vital Records, P.O. Box 68760, Aortic IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2⊠No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 200 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Catherine

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

10 N. Greene St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M. D.

32. Registrar's Signature

Smith

5

386847903

Baltimore,

200 1

MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1850 M Charles W Parkette 10 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Housel Coont General 510 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 □ F 213-36-1106 April 1, 1930 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Howard Director 10e. Street and Number 10g. Citizen of What Country? 21029 U.S.A. 6536 S. Trotter Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighting Fireman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Winfield Parlette Ruth Elizabeth Purdum 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6536 S. Trotter Rd. Clarksville, Maryland 21029 Mrs. Ann H. Parlette Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/24/07 Highland, Maryland Mt. Zion United Methodist Church 21. Simajure of Funeral vice Licen ee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Sater the diseas e, or complications that cause of List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) Arres /Medical Due to (or as a consequence of): Examiner Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 28 No 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the recent of the fundamental of the funeral Director: After this of the funeral director after this of the funeral director. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 058342 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Elkridse 8186 Ch. Lack Brown 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Physician	
/Medical	
Examiner	

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	For State of Wary		rtificate of L		Reg.	2001	34251					
cian	1. Decedent's Name (First, Middle, Lest)	C			2. Date of Death Month	Day Year	3. Time of Death					
lical	James Thomas Reiter	, Sr.			1	2007	11:19p M					
iner	4a. Facility Name (If not institution, give street and number)  1602 Deep Point Road		4b. City, Town, or Woolford	Location of Death	1	4c. County of Dea Dorcheste						
1	5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	Q Riv	thplace (State or Foreign					
r	213-28-9702 1 <sup>™</sup> 2□ F 77	Yrs.	Months Days	Hours Min.	July 25,	1930	MD MD					
	Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Lo	ocation				10d. Inside City Limits					
ō	MD Dorchester	1 □Yes 2☐No										
irec	10e. Street and Number	Woolfor	10f. Zip Code		10g.	10g. Citizen of What Country?						
a D	1602 Deep Point Road		216	677		USA						
Funeral Director	11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi						
ğ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: white						
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired,	ation Juring most of wor	king   16l	o. Kind of Business	/Industry					
du	Elementary/Secondary (0-12) College (1-4or 5+)	lite.				1 1						
ပိ	12 17. Father's Name ( <i>First, Middle, Last</i> )		phone ins		ne (First, Middle, Mai	elephone den Surname)	company					
To Be	Frank Reiter			Marie	Kess1	.er						
	19a. Informant's Name/Relationship (Type. Print)	1			ral Route Number, C	-						
	Catherine A. Reiter, wife				Moolford,							
	20a. Method of Disposition  1											
	21. Signature of Euneral Service Licensee, 22. Name and Address of Facility Sterling Ashton Schwab Witzke F 1630 Edmondson Ave., Catonsville, Md. 21228											
ner	d											
/Medical Examiner												
Completed by Physician/IV	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of delivery  Month Day Year						
d by PI	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause give	en in Part I.			o the cause of death?					
ete		-			24a. Was an	24b. Were a	utopsy findings available					
dmo					autopsy performe	prior to d? death? tNo 1 □ Yes	utopsy findings available completion of cause of					
Be C	25. Was case referred to medical			26. Place of Dea	th (Check only one)	110	5 2 140					
	examiner? 1 ☐ Yes 2 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	r: 4 🗆 Nursing H	ome 5 Residenc	e 6 □Other (Spe	ecify)					
ition:	27. Manner of Death  1	28b. Time o Injury	Work	rat ?? /es 2 □ No	28d. Describe how	injury occurred						
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - building, etc. (S	At home, farm, str			28f. Location (Stree City or Town, S	at and Number or R State)	ural Route Number,					
Medical Certification: To	29a. Certifier (Check only one)  1 Certifying Physician: To the best of machine in the basis of examiner: On the basis of examiner and manner stated.	amination and/or in										
M	29b. Signature and title of certifier  Mullefifer, affeld	ing physic	-	number		Date signed (Mon						
	30. Name and address of person who completed cause of death V. Mehda, M.D., Byrn St.,											
tate trar	31 Date filed (Month Day Year) 32 Begistrar's		Garles									
- I	Of Barron Maria	N 805 10	Charles Asses									

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	State of Maryland / Department of Health and Mental Hygiene	UI

34258

			1 - For State Registrar	Otato of Ma	,		ificate of l	Death		Reg. No.		
	g .	ş.	1. Decedent's Name (First, Middle, La	ist)					2. Date of De		Yeer	3. Time of Death
	Physici /Medic		MARRIS	REED					(1)	23	2007	5:30 PM
	Examin		4a. Facility Name (If not institution, given Manorcare	re street and number)		4b. City, Town, or Location of Death  Baltimore  4c. County of Death				n		
I	Funeral Director			Sex 7. Age 1 M 2 □ F	(In yrs. last birt.	,,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 4,	th 1924	9. Birth Con	nplace (State or Foreign untry) MD
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	orLoca	ition					10d. Inside City Limits
	Ne Maryla Be-f sho	ctor	MD					timore				1 Yes 2 No
	th with the 23e or 2 unit be in	Funeral Director	10e. Street and Number 4800 Yellow Wood Ave	enue	rue		10f. Zip Code 21209		10g. Citizen		n of What Country? USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic avant. It a Medical Exameration that be multiled at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	as Decedent of H es, specify Cuba Yes 2 2 No	spanic Origin? (S) n, Mexican, Puerto Specity:	pecify Yes or No o Rican, etc.)		Race - Amei Black, White ecify: Afr:	
ည	72 ho natur	eted	15. Decedent's E (Specify only highest gr		16a.	Deceder	nt's Usual Occupa	ation during most of work	king	16b. Kind	of Business/I	Industry
altimore, Maryland 21215-0036	d within giene.	Completed	Elementary/Secondary (0·12)	College (1-4or 5-	-)		noruse retired	during most of world)		pł	narmacy	
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ya	ould to Ment arked	To.	Henry H.							ena Johr		
Jar	2 shot and is m		19a. Informant's Name/Relationship					and Number or Ru				(ip Code)
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Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lice	nse Jones				ss of FacilityWyli mor Street:				21217
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line	the death. Do n	ot enter	the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
/Me	Physician		Immediate Cause (Final disease or condition SEPTICEMIA									Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence o	of):	1					
ı	Examiner	Sequentially list conditions.  b. URINARY TRACT INFECTION										
	od sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or):								
	and I-tran	хап	that initiated events resulting in death) Last	c								
68760,	rtificate be executed ng physician and s as the burial-transit	Medical Examiner		d								
			IF FEMALE:	23c. If yes, outcome of	of pregnancy					224	Data of dali	
P.O. Box	The law requires that the death cell at the has been signed by the attendire bage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death		ctopic pregnancy Other (specify)			230.	. Date of deli Month	Day Year
S, 7.	w requires that It been signed by should be detac	by Ph	Part II. Other significant conditions		_	the und	erlying cause give	en in Part I.				the cause of death?
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Division of Vital Records,	The law r te has be age 2 sh	Completed	TYPE II	DIABETES	, ME	-21	Tus				prior to death?	topsy findings available completion of cause of 2 No
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<u>-</u>	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatier	t 2□ER/Out	patient	3□ DOA Oth	er: 4 Nursing H	ome 5 🗆 Resi	dence 6	Other (Spec	cify)
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<u>s</u>	or Attano after death Diractor: in by the	icat	2 Accident investigation 3 Suicide 6 Could not be	98 Place of Injur	ny - At home, far	m etree		165 2 1140	28f. Location (	Street and N	umber or Ru	ıral Route Number,
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	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funerel Diractor: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Processing (Check only one)	nysician: To the best of miner: On the basis of	examination and	, death o	occurred at the tin stigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	o the ithin ( o the emple	Med	29b. Signature and title of certifier	and manner stat			29c. License	number		29d. Date si	igned (Montl	h, Day, Year)
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			30. Name and address of person who		ath (Item 23a) /	Type Pr					-	
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¥ .	Sta		31. Date filed (Month, Day, Year)	3 Registra	r's Signature	Corn	LED.	2815TER				
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State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1: DOPM 2007 Dale Stringer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WALDORF CHARCES 8804 COTTON GRASS mi | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/29/1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 220-52-4015 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be rectified at 1 ☐ Yes 2 √ No Charles Waldorf Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20603 8804 Cottongrass St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ā Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 🏋 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Health Care Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H tant: If Item 27 is marked off Charles Schneider Myrtle M. Leonhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis Stringer (Husband) 8804 Cottongrass St. Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny injury or once. Trinity Mem. Gardens | 10/26/2007 | Waldorf, MD 22. Name and Address of Facility

Lee Funeral Home 21. Signatura of Funeral Service Licensbe X Frank mo0257 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Dones Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BREAST CANCER **Physician** EARS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/22/2007 00038147 BENJAMIN R PIMENTEL, MD 601 PRST OFFICE RD #1A, WALDURF MD 20602 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month Pay Year) 5 Source)

Registrar

			1 - State Registrar		aryland /			of Health a of Death			Reg. No.	2001	34200
	Physici	an	Decedent's Name (First, Middle						2	. Date of De Month	Day		3. Time of Death
	/Medi			E. Smith						ct.	23,	2007	7:15a M
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			715 Maiden Choi		e (In yrs. last	hirthday)	If Under 1 Y		24 Hrs.   p	. Date of Bin			onlace (State or Foreign
	Funeral Director		215-01-1909 Usual Residence of Decedent	1□ M 2☐ F	94	Yrs.		ays Hours	Min. (Month, Day, 10/14/1		y, Year)		
land	A III		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Depertment of Health and Mental hygiene. Important: If Item 27 is marked other then "neturel", or Items 23s or 28s-f ehow eny injury or other traumatic event, the Medical Exempter must be notified at		Funeral Director	10e. Street and Number 715 Maiden Choic	e Ln., PV60	5	10f. Zip Code 21228				10g.		. Citizen of What Country?	
deeth	3 S S	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent	of Hispanic Orig Cuban, Mexican	gin? (Speci	fy Yes or No	)-	14. Race - Ame	
USO urs efter	of, or its	þ	1 Never Married 2 Marrie 3 Widowed 4 Moroced	Armed Forces?  ad 1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:			Yes, specify		, Puerto Ri	can, etc.)		Black, White	hite
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Baltimore, Maryland 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours eft	Ith and M 27 is mar traumat		19a. Informant's Name/Relationsh Bonnie Scott, n					m Road,					
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			23a. Part1. Enter the disease, or	complications that caused	d the death. D						rrest,		Approximate
D.			shock, or heart failure. List of Immediate Cause (Final	inly one cause on each li	1		Mas-	S					Interval Between Onset and Death
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		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequenc	e of):							<del></del>
petno	d ansit	교	cause. Enter underlying Cause (Disease or injury that initiated events	6									
exec	an an rial-tr	EXa	resulting in death) Last	Due to (or as	a consequenc	ce of):							
coronal de executed	physicien and s the burial-transit	edical Examiner		d				<u>.                                    </u>					
_	as th		IF FFMAN F.								-		
death certi	tendii r use	an	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		ath 3□	Ectopic pregr	nancy				23d. Date of del	
	ed by the attending detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 🗀	Other (special	(y)				Month	Day Year
ecords, F.O.	d by letach	F.	Part II. Other significant conditio	P contributing to death h	out not reculting	a in the	adashina asus	o awas in Part I		230 Did t	obaccou	iee contribute to	the cause of death?
	signe d be c	à	Tarrit, Ottor significant contains	is contributing to death t	od not resulting	g 111 (110 U	idenying caus	e giveirii raiti.					obably 4 Onknown
	been signe should be	Completed		<del></del>	<del></del>								
		μ								24a. Was autop	an psy ormed?	prior to death?	topsy findings available completion of cause of
T Pe	r this certificete ha ral director, page 2									1 Yes	22 No	1 ☐ Yes	2 <del>1</del> 10
VII.	certif	Be	25. Was case referred to medical examiner?	Hospital:				Othor		Check only			
5 <sup>4</sup>	this at di	۲.	1 Yes 2 No	1 ☐ Inpation		Outpatier  o. Time of		4 11401		d. Describe		6 Other (Spe	cify)
DIVISION OF VILAI DECOLUS,	Atter fune	for	1 Pending	(Month, Da	y Year)	Injury	м 200.	Injury at Work?		d. 00301100	now and	y cocanica	
IS I	death. ctor; A y the fu	flca	3 ☐ Suicide 6 ☐ Could n	ot be 200 Place of la	iury - At home	farm str				f. Location (	Street an	d Number or Ru	ıral Route Number.
	rs elter death el Director; / ed in by the f	Certification:	4 Homicide determi	building, et	tc. (Specify)	rum, su	oot, ractory, or			City or To			
To the Hospital	within 24 hours effer death.  To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical	Physician: To the best Taminer: On the basis of and manner st	of examination	ige, deatl and/or in	occurred at t vestigation, in	he time, date and my opinion, deat	d place, an th occurred	d due to the l at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To #	To the	¥.	29b. Signature and title of certifies					icense number				te signed (Mont	
(	~		1/2	MD				4744					3, 2007
	8		Hrof (9214	who completed cause of	Vaide	< C.	n0,0	Lane	Ca	LUNS	vil	e M	asw.
	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2 5 2	39. Registr	rar's Signature	long	De s						
рнмн	17 Rev 1/2	001				1							

ORIGINAL

10+1

Division or Vital Records, P.O.

State Registrar 31. Date filed (Month, Day,

Monya-Tambi 9000 Franklin Square Drive, Boltimore, MD. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 5 2007

			For State	State	of Maryla		artment of F		nd Ment			07	34262
			Registrar  1. Decedent's Name (First, Middle	, Last)		001	tineate or i		2. Da	ate of Death	3	0 1	3. Time of Death
	Physicia		, , , , , , , , , , , , , , , , , , , ,	Anna	Helen	Stack				onth つのもへわら	Day er 24,20	Year	8:00 A M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	r Location of		<u>JC COD</u> C	4c. County of		0.00 11
•	E Aumin	Ο.	Quail Run Ass	isted Li	ving		Pei	rry Hal	11		Bal-	timo	re Co.
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Da	ate of Birth fonth, Day,	Year)	9. Birthp	lace (State or Foreign try)
	Director	ļ	213-36-0228	1□M 2⊠F	86	Yrs.			Fe	b. 12	,1921		nyslvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	ocation					1	0d. Inside City Limits
	faryla sho ed at	ō		1 ± 1 m = 10 =		•		na.					1 ☐Yes 2X No
	the N 28a-1 notifi	Director	Maryland Ba 10e. Street and Number	ltimore			10f. Zip Code	Edd	gemere	10	g. Citizen of W	hat Coun	try?
	with 3a or t be i		7209 Waldma	n Ave.			2121	19			United	Sta	tes
	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status		ecedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origi	in? (Specify Y	es or No-			an Indian,
٥	after or ite		1 ☐ Never Married 2 ☐ Marr		Forces? s 2X No		1 ☐ Yes 2X No	Specify:	rueno nican	, etc.)	Specify:	, White,	etc.
2-003p	ours iral",	d by	3  Widowed 4 □ Divorced	Year or	Dates:								White
ה	72 h "natu dical	Completed	15. Deceden (Specify only higher	's Education at grade complete	d)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	1	l6b. Kind of Bus	siness/Ind	dustry
7	within iene. than 'the Med	ldm	Elementary/Secondary (0-12)	College 3 Year	(1-4or 5+)	i	istered N				IIoalth	<b>C</b> = **	. Drandan
N	filed v Hygie other t		17. Father's Name (First, Middle,		5	ı, eg	Tacered t		's Name (Firs	t, Middle, M	neartii faiden Surname		e Provider
ali	d be antal	) Be	Charles Jose	,	r			1	Ella M	ae Fra	nkhous	er	
<u></u>	2 should be and Mental is marked raumatic ev	ပ	19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number	or Rural Rou	ite Number,	City or Town, S	State, Zip	Code)
<u>8</u>	and 2 sealth ar		Claude E. Sta	ck, Jr.	(Son)	720	9 Waldmar	a Ave.	Edge	mere,	Maryla	nd :	21219
<u>a</u>	一工事者		20a. Method of Disposition		206	. Place of Dispo	osition (Name of matory or other place	ce)	Date	2	20c. Location - 0	City or To	wn, State
Ē	it. Pages intrent of l		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		m State		ge Mem, I	1	0/26/2	007	Dorse	ey, 1	Maryland
<u>=</u>	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licensee		2	2. Name and Addre Duda-Ruck	ess of Facility	ral Ho	me of	Dundall	k Tı	nc
n	e a m e		Si Kalo			i i	7922 Wise	AVE.	Dund	alk. N	Marylan	•	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	nt caused the de	eath. Do not en	ter the mode of dyir	ng, such as c	ardiac or resp	oiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	,	lene	nhe					- î	Opert and Death
	/Medical		resulting in death)	Due Due	onras a gon	equence of):	1 .	0	L				
	Examiner	L	Sequentially list conditions.	b	ere!	18 OV4 C	ulas 2	ven	1				10413
7	sit sd	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a cons	equence of):	/						100
/	be executed ici <b>a</b> n an <b>d</b> burial-transit	Examiner	Causs (Dissass or injury that initiated events resulting in death) Last	c	to (or as a cons	equance of):	unn					-	1) 94/3
8/60,	rate be executed ohysician and the burial-transit				(	7-7							/
2	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	edical		d	***								
XOA	w requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf pre		_				23d. Date	of delive	ery
ň	atter d for t	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2□F egnant at time o		⊒Ectopic pregnanc ⊒ Other <i>(sp</i> ec <i>ify)</i> _	У			Mor	ith	Day Year
o	the cy the achec	hysi	9 Unknown	9□Un	known								
7	s that ned b	by PI	Part II. Other significant condition	ons contributing to	death but not r	resulting in the u	inderlying cause giv	ven in Part I.	2	23e. Did tob	acco use contr	bute to the	ne cause of death?
ĕ	quire on sig uld b									1 ☐ Ye	s 2 No	3 Prob	ably 4 Unknown
ecords,	aw re Is bee 2 sho	Completed							2	24a. Was ar autops	24b. V	Vere auto	psy findings available mpletion of cause of
r	The lay	mo:								perform	ned2 d	eath?	2 □ No
Vital	ysician: The la is certificate had director, page 2	Be C	25. Was case referred to edica examiner?					26. Place	of Death (Chi	eck only one	e)		
	> 0 0 0	To 1	1 Yes 2 №	Hospital: 1	☐ Inpatient 2	☐ ER/Outpatie		4 La Nur	sing Home	5 🗌 Reside	nce 6 □Othe	er (Specif	y)
n or	ding Ph h. After th funeral		27. Mann p of Death 1 atural 5 □ Pendir	(8.4	ite of Injury Ionth, Day Year	28b. Time of Injury	Wo			Describe ho	w injury occurre	∍d	
<u> </u>	Attendideath.	cati	2 Accident investi 3 Suicide 6 Could	gation				Yes 2 □ N					I Day to Alignaha
DIVISION	or Attending ifter death. Director: After in by the funer	Certification:	4 Homicide determ	inod Zoe. Fix	ace of injury - A ilding, etc. <i>(Sp</i> e	t nome, tarm, st ec <i>ify)</i>	reet, factory, office		281. L	city or Town	reet and Numbe i, State)	er or Hura	al Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyii	o Physician: To	the best of my l	knowledge dea	th occurred at the ti	ime, date and	d place, and o	lue to the ca	ause(s) and ma	nner as s	stated.
	24 hc 24 hc Fun etely	Medical		Examiner: On the			nvestigation, in my						
	To the within 2 To the complet	Me	29b. Signature and title of certifie		^		29c. Licens	se number	2	29	9d. Date signed	(Month,	Day, Year)
)	->-0			/ N	11)		1	144	+93		10/2	410	7
,	0-		30. Name and address a person	who completed ca	ause of death (I	tem 23 <b>a</b> ) (T <b>l</b> /pe	Print)	1	1//	1-	1017	// \	/
	ツ		141	a /	6730	) (to)	ahud	the	152	U,	NO1 6	1220	2
	Sta	ite	31. Date filed (Month, Day,-Year)		Registrar's Si	gnature	- NO -	7					
	Regist	ar	OCT 2 5	2007	ELGIAR .	13 60	BULL						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State	State of Mary	land / Depa	rtment of He tificate of D	ealth and Me			34263
			Registrar  1. Decedent's Name (First, Middle, La	st)	0611	moate of L		Reg. 2. Date of Death	. No.	3. Time of Death
	Physici		Wanda	Szvik	4			October	Day Year 22.2007	10:15P <sup>M</sup>
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or I		OCCOBCI	4c. County of Death	
1			GenesisElderca	re-Frankli	nwoods	Rosedal	Le		Baltimor	е
	Funeral		Social Security Number     6. S	DM WW	yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye	ear) 9. Birth	place (State or Foreign intry)
	Director		220-34-5724 Usual Residence of Decedent		87 Yrs.			Feblo, 1	.920 Pola	and
	land		10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
	Man,	ţō	Md. Balti	nore	Middle	River				1 ☐ Yes 2 🔀 No
	th the	lrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
	th wil	alD	3202 Everlasti	ng Lane		21220	)		U.S.A.	
	or dea	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. W	as Decedent of His Yes, specify Cuban	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "netural", or Items 23s or 28s-f show any injury or other traumatic event, If a Modical Exaction from the notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖁 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Į.	□ Yes 2√ No	Specify:		Specify: Wh	nite
2-0	72 ho natur	Completed by	15. Decedent's E (Specify only highest gra	ducation	16a. Decede	ent's Usual Occupat	tion uring most of working	161	b. Kind of Business/Ir	ndustry
2121	within ene. then *	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	sing most or working			
2	filed w Hygier Ither to		11th 17. Father's Name (First, Middle, Last		Sear	nstress	18. Mother's Name	(Fire Middle Ada	Bridal	Shop
and	ntal F	Be	Teofil Smolin				Stefani		iden Surname)	(unk)
Maryland	2 should be filed withir and Mental Hygiene. is marked other then sumatic event, It eller	은	19a. Informant's Name/Relationship (		19h Mailing	Address (Street a)			ity or Town, State, Zi	n Code)
$\mathbf{Z}$	and 2 saith ar n 27 is		Martha Szyjka							,Md21220
ē,	ges 1 and 2 it of Health if item 27 or other tra		20a. Method of Disposition	2	20b. Place of Dispos		Da		c. Location - City or T	
Ē	Pages nent of I ant: If its		1√2 Burial 2 ☐ Cremation 3 ☐ 1 dther (Special		Holy Ros		· 1	-2007Ba	ltimore,	Maryland
Baltimore,	permit. Pag Department Important: i any injury c		21. Signature of Funeral Service Licer							Home, PA
<u>-</u>	8077 29		Tober 120	la					more, Md	1. 21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	r the mode of dying			1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	altronic h	Vier Capile	ic hypo	xic rest	3 ratory	tailure	Onool and Dodg.
	Examiner			Due to (or as a o	halequence on	19	, U	1:00		
	Mayer 1	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):	e pulmi	onasy a	Bease	_	
J	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				,		4	
, O	en an rial-tr	Exa	resulting in death) Last	Due to (or as a co	ensequence of):					
68760,	auth certificate be executed attending physicien and for use as the burial-transit	edical		d						
	entific ding p	/Mec	IF FEMALE:	220 16 100 0 100 0 100	ar dierit.					
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of post 1 Live birth 2 4 Pregnant at time	Fetal death 3 □I	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
P.O.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	or death 3	Other (specify)				
	res that igned b be deta	by Pł	Part II. Other significant conditions	ontributing to death but no	ot resulting in the un	derlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to t	the cause of death?
rds	w require. been sig should b	ed b	Cardiac arrest	10/9/07, A	trial Fi	brillation	7	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Gunknown
Records,	e law requ has been je 2 shouli	plet	Moderate gortic	Stenosis,	Severe	. pu/mor	YOUN	24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
Ä	The I	Completed	Lynertension	/				performed	d? death?	2□ No
Vital	ding Physicien: Th h. After this certificate funeral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of \	Physic this c	P.	1 Yes 2 No	- 1	2 ER/Outpatient	3 DOA Other	4 Nursing Hom		e 6 Other (Speci	fy)
no	ding F	llon	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	3d. Describe how	injury occurred	
Division	Attandi death. ctor: A y the fu	flcai	2 Accident investigatio 3 Suicide 6 Could not b		At home, farm, stre			Bf. Location (Stree	at and Number or Rur	al Route Number.
Ö	s efter	Certification:	4 Homicide	building, etc. '(S	Specify)			City or Town, S	State)	
	To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: Atter this certifics completely filled in by the funeral director, is	Medical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	ysician: To the best of moniner: On the basis of exa	ımination and/or invi	occurred at the time estigation, in my opi	e, date and place, ar inion, death occurred	nd due to the caus d at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	ithin ithin omple	Mec	29b. Signature and title of certifier /	and manner stated.		29c. License	number	29d.	Date signed (Month,	Day, Year)
	F \$ F 0		17- 5/		11	DHE	-7/-/-	100	1-ha= 72	7007
1	2		30. Name and address of person who	completed cause of death	(Item 23a) (Type, P	rint)	100	VC	tober 23	a vv/
į	+		Tom Edmondson	1 MD 9105 F	Tanklin S	guese Dr	st. 31.	2 Balt	imore 1	1D 21237
	Sta		31. Date filed (Month, Day, Year)	32. Regietrar's	Signature		1			
	Registr	-	OCT 2 5 2	007 Marie	, D. Ag	ari)				
DH	MH 17 Rev 1/2	001								

State of Maryland / Department of Health and Mental Hygione

			1 - For State Registrar	State of Marylan		tificate of L			leg. No.	07	34264
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Rianche	Schl	esin	ger		2. Date of Dea Month	Day	Year	3. Time of Death 9/059 M
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death			ty of Death	
			SUMMERVILLE WOODWAR			BOWIE				CE GEO	
Shedan	Funeral Director		0/ 3-12-/334	7. Age (In yrs. I	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08/22/1	(, Year)	9. Birthpl Count	ace (State or Foreign ry) NY
	yland now at		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation				10	d. Inside City Limits
	ne Mar 8a-f st ottfled	Director	MD PRINCE GEO	RGE'S BOW	IE						1 Yes 2 No
	with the		10e. Street and Number	DD #150		10f. Zip Code		ľ	10g. Citizen of		ry?
	ns 2% mus	Funeral	14997 HEALTH CENTER	2. Was Decedent Ever in U.	S. 13. W	20716 as Decedent of H	ispanic Origin? (Sp an, Mexican, Puerl	pecify Yes or No-	14. Ra	S.A.	
980	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates:	- 1	Yes, specify Cuba	an, Mexican, Puèrti Specify:	o Rićan, etc.)	Speci	ack, White, e M ify:	HITE
21215-0036	ר 72 ho "natur edical"	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decede	ent's Usual Occup- ind of work done of	ation during most of work f)	king	16b. Kind of E	3usiness/Ind	ustry
212	y withir giene. r than the Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		ARIAN	"		CITY OF	NEW Y	ORK
pu	be filed ital Hygi od other event, tl	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	,	Maiden Surna	,	· · ·
Maryland	should be and Mental Is marked o	မ	AARON  19a. Informant's Name/Relationship (Typ	e. Print)	PAC		GUSSIE and Number or Ru		r City or Town	TEPF	
	nd 2 salth all		JUDITH SCHLESING				I AVENUE				3000)
Baltimore,	Pages 1 a nent of Hez ant: If Item ary or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Real Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content Content	emoval from State 20b. P	lace of Dispos emetery green HEBRON	ition (Name of atory or other place	<sup>(ce)</sup> 10/24	Date / 2007 F	20c. Location LUSHIN		vn, State
Balti	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service License	7	1	Name and Address		OL LEVIN			INC. MD 21208
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death cause on each line.					rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		vasculo-	caccide	nt			
104	Examiner		Esquentially list conditions.	failure t	o thr	ive					
1	nted Insit	Examiner	Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
50,7	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	uence of):	·	<del></del>				
68760,	icate b physic s the bi	ledical	d								
Box (	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome pf pregna 1□Live birth 2□Fetal					23d. D	ate of delive	ry
O. B	at the deat by the atte	Physician/N	in the past 42 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown		Ectopic pregnancy Other (specify)			N	Ionth	Day Year
Р.О	uires that the signed by detaction		Part II. Other significant conditions con	ributing to death but not resu	ulting in the und	derlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
ords	w requires been sig should be	d ba	Osteoponosis				····	1 🗆 Y	es 2□No	3 ☐ Proba	ably 4 Unknown
Records,	: The law r cate has be page 2 sh	Completed by	emphysemo					24a. Was a autop	sy	prior to con	sy findings available appletion of cause of
			OF Was area informed to modified						2 <b>2</b> No	death? 1 ☐ Yes	200
Ξ	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1   Inpatient 2	ER/Outpatient	3□ DOA Othe		th <i>(Check only or</i> ome 5 ☐ Resid		that (Canail	
ו סר	ding Phy h. After thii funeral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	y at	28d. Describe h			)
Division	Attendir death. ctor: At y the fu	catic	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1□	Yes 2□No	001   11 10			
Divi	afor Al after d Direct d in by	Certification:	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow	itreet and Nurr rn, State)	nber or Rura	Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Sertifying Phys (Check only one) 1 Medical Examir	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tine estigation, in my o	me, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s) and n	nanner as st	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License			29d. Date sign		Day, Year)
	1		> K-JTCll	3		MD 2	8604		10/	23/	07
	6		30. Name and address of person who con	noteted cause of death (Item	23a) (Type, P	701 R	8604 Soure, 1	MD 20	07/6		
V	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signar	ture	201 10	1				

DHMH 17 Rev 1/2001

Registrar

OCT 2 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thomas 9:13 Octobers 2007. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Randallstown Baltimore Northwest Hospital 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) Funeral Months Days Hours 1 M 2□ F 61 218-48-3024 Director May 19, 1946 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Catonsville Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 6104 Moorefield Road United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas and Elementary/Secondary (0-12) 12 College (1-4or 5+) Draftsmen Electric Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellwood V. Thomas Catherine Sears ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Thomas - Mother 6104 Moorefield Rd., Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery | 10-25-07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 The bear 23a. Part1. Enter the disease, or complications that caused the death. D., not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 TUnknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 TYes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1-☑Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the funeral director, within 24 hours a

To the Funeral I

completely filled

Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maple Road Linthicum, ma 21090 KARIPINENI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 34266

		1- For State Certificate Registrar		Reg. No.	01 3420
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death
ral Exami	ner	Ronald Lee Taylor Jr.  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	October 20, 2007	1716 hrs
		11011 St. Martins Neck Road	Bishopville	Worcester	
Funeral Director		5. Social Security Number 4966 6. Sex 7. Age (In yrs. last birthday) 213-92-4967 XXM 2 F 41	Months Days Hours Mir	— ` 1r.	oreign
·		Usual Residence of Decedent	/rs.	11/24/1903	Country) MD
nd show any ice,	٦٢	MD Anne Arundel Glen	cation Burnie		10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
th the 23a or notifie		6506 Jefferson Place	21061	USA	
eath wi	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) 14. Race - A White, e	merican Indian, Black, tc.
after d al", or	by Fu	or Dates:	Yes 2 X No specify:	Specify:	white
hours "natur	ted t		lent's Usual Occupation (Give kind of most of working life. DO NOT use re	tired)	
5-0036 led within 72 Hygiene. other than the Medical	Completed		County Waste Mgm	nt. Cou	unty
		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)	
e, MD 2121 I and 2 should be f Health and Mental item 27 is marked	To Be	Ronald Lee Taylor Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mail		Anne Rosemary Tay Rural Route Number, City or Town, S	
MD 12 shor th and 127 is umatic	_			Linthicum MD 21	
imore, MD 2 Pages I and 2 shoument of Health and I tant: If item 27 is no or other traumatic		1 Burial 2 X Cremation 3 Removal from State crematory or		Date 20c. Location - Ci	ty or Town, State
timent (reant)		4 Donation 5 Other Specify: Chesapea	VIII - AVELE - COLOU-VI		sville MD
Baltimore, permit. Pages I and Department of Heal Important: If iten		M01364 1	Name and Address of Facility Si 2nd Ave SW Glen	ngleton Funeral & Burnie MD 21061	Cremation Srvc
Physician		23a Fart I Enler the isease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical ≟xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Lobar pneumonia  Due to (or as a consequence of):			Death
		Sequentially list conditions,  b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
nsit ed	Examiner	events resulting in death) Last Due to (or as a consequence of):			61
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	d.  X UNPENDED #5 PETFH 874.  #1 23a PTF 27 PETME 98	12/4/97/JJ07 Tr		
3760 ficate b g physi s the bu		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of de	
Ox 68 leath certifi	Physician	past 12 months?  4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	nancy Month	Day Year
the dez	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I	23e. Did tobacco use contribu	te to the cause of death?
, P.O. res that the signed by be detach		Cirrhosis of liver			Probably 4 🗸 Unknown
ords, w requir us been s should	Completed by				re autopsy findings available or to completion of cause of
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n of Vit ding Physic L. After this funeral dir	1.	1 ✓ Yes 2 No Prospital 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of		ing Home 5 Residence 6 🗸 0  28d. Describe how injury occurred	
ttendir feath. tor: A	atio	1 X Natural 5 Pending Accident Investigation (Month, Dey,Yeér)	1 Yes 2 No		
Divis al or A s after al Direc ed in by	Certification:	3 Suicide 6 Could not be determined	reet, factory, office building, etc.	28f. Location (Street and Number of Town, State)	or Rural Route Number, City
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /		4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, an	nd due to the cause(s) and manner as	s stated.
Fo the within Somplet	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurred		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		(Month, Day, Year)
,	ļ	30. Name and address of person who completed cause of death (Item 23a)	O.O.IVI.E.	October 22, 2	2007
0			n Street, Baltimore, MD 2120	01	
St	ate	31. Date filed (Month, Day, Year) 31 Registrar's Signature	Ale I		

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician Binner Vermillion Octob 2 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince 6 Whit field-Chapel Lan If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 🗌 M Director 579 94 7309 Sept 8, 1960 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~" any hiury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Prince Maryland | George's Lanham 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 5648 Whitfield Chapel Road 20766 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 11. Marital Status 1 ☐ Yes 2 💢 🌠 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21770 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Mills Betty Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Vermillion (HUSBAND) 5648 Whitfield Chapel Road #103, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 Other (Specify) 2007 Suitland Maryland 21. Signature of F 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter shock, or Immediate raise (Findisease or resulting in death) **Physician** rterios delatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of) P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Onknown Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1□ Yes 2□M0 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examinar? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1. Natural e Hospital or میں. 24 hours after death. عوال است 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

3 acy

32. Registrar's Signature

219

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Alice Elizabeth Vincent CTOBER 20 2007 052h 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 16, 1 BALTIMORE AGNES HOSPITAL 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 🗓 F 82 1925 216-14-8537 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Howard Elkridge 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowanberry Drive #408 21075 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harsey Laverne Shutt Mary Henrietta Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Kingston Park Lane West Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery 10-24-2007 Baltimore, Mary1 Lawrence M. Vincent/Son 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Licensee Kepaus Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EPSI. disease or condition resulting in death) Due to (or as a consequence of): 02517 HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DRONARY Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 1 Natural 2 Accide (Month, Day Year) Injury 3[ 28e. Place of injury - At home, farm, stree building, etc. (Specify)

**Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

"natural", or Items 23a or edical Examiner must be

th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical

permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other trauonce.

should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

**Funeral Director** 

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Completed

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attending physician and for use as the burial-tran cate has been signed by the a page 2 should be detached certificate has

funeral director, After this

Physician/Medical <u>გ</u> Completed Be Certification: To

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Examiner

Hospital or Attendi 24 hours after death. Funeral Director: A filled in by the To the Hospital or within 24 hours at To the Funeral D

	25. Was case referred to medical examiner?
	1 ☐ Yes 2 No
1	27. Manner of Death

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	28f. Location (Street and Number or Rural Route Nu City or Town, State)	ımber

29a. Certifier (Check only one)	1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	sis of exa	y knowledge, death occurred at the time, date and place, and due to th amination and/or investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the
29h Signature and	title of certifier	4m	29c. License number	29d Date signed (Month Day

h	29c. License numb
*	653

	asis of examination and/or inves ner stated.	stigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
ifier	h	29c. License number	29d. Date signed (Month, Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL

DOTOBER	20	2007	,

Registrar

			For 1 State		of Maryland /	Depa		f Hea	Ith and N	Mental Hy	gien	•	34269						
**	Physici	an	1. Decedent's Name (First, Middle, Vivian M. V	Last) ataha		061	incate (	JI De	auı	2. Date of Dea Month	Day	Year	3. Time of Death						
8	/Medi Examir		4a. Facility Name (If not institution, Future Care Che		mber)			n, or Loc	ation of Death	OCTOBE	4c. Co	ounty of Death Anne Ar							
	Funeral Director		5. Social Security Number 216–18–3037	.Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. last i	oirthday) Yrs.	If Under 1 Y	ear If l	Under 24 Hrs. ours Min.	8. Date of Birt	h		lace (State or Foreign try) MD						
	Maryland e-f ehow fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arunde1	10c. City, To		cation ersvill	e				1	0d. Inside City Limits 1 ☐ Yes 2 No						
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or itame 23a or 28e-f ehow other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 335 Butternut C 11. Marital Status		edent Ever in U.S.	13. y		1108	nic Origin? (S	pecify Yes or No		uSA Race - Americ	an Indian,						
9000	ours after trai', or its Exemine	by	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced		2X No		TYes, specify t		рөсіfy:	o Hican, etc.)		Black, White,							
21215-0036	d within 72 h giene. or then "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (		(Give life. L	dent's Usual Oo kind of work do DO NOT use re Vireman	one durin etired)	i g most of wor	king		of Business/Inc							
Maryland	ould be file Mental Hy, arked othe	To Be C	17. Father's Name (First, Middle, La  Owen Tormolla					18.		ne <i>(First, Middl</i> e, e Mae No		ımame)							
, Man	and 2 sho ealth and ! m 27 is ma		19a. Informant's Name/Relationship Mrs Joyce Mille		er 3	335 E	Buttern	ut C		ral Route Numbe	ille	MD 211	08						
Baltimore,	95 = 5		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	cify)	State	Have	sition (Name of natory or other en Ceme	tery		Date 27/2007	G1en	tion - City or To	MD						
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (final disease or condition resulting in death)	a	Paused the death. Deach line.  1 7 0 CAR 1  (or as a consequence)	MAL					rest,		Approximate Interval Between Onset and Death						
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one) 2 Medical Ex	aminer: On the b	best of my knowled asis of examination a ner stated.	ge, death and/or inv	n occurred at the restigation, in r	ne time, d	ate and place n, death occu	, and due to the orred at the time, o	cause(s) and date and pla	nd manner as st ace, and due to	ated. the cause(s)						
	To the P within 24 To the F complete	ž	29b. Signature and title of certifier				29c. Lic	cense nur	mber		29d. Date s	igned (Month,	Day, Year)						

State Registrar

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MOHIT NEGI 31. Date filed (Month, Day, Year) OCT 2 5 2007

D57531

30. Name and address of boson who completed cause of death (Item 23a) (Type, Print)

NEGI 8601 VETERANS HIGHWAY, SUITE 2049 MILLERSVILLE, MD 21108

OCTOBER 23, 2007

MD

86 OI VETERANS
32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 [] [] 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ocotber 22, 2007 **Physician** 3:00PM M VACCA JOHN PETER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) January 29,1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2□ F New Jersey 140-16-3473 85 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 No Director Cockeysville Maryland | Baltimore 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21030 USA 10811 Lakespring Way Funeral . Was Decedent Ever in U.S. Armed Forces? ₩XYes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc 1 Never Married Married 1 ☐ Yes XX No White Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Pile Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alphonse Vacca Mary Petrizzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. Wife 10811 Lakespring Way Cockeysville Maryland 21030 Ida Theresa Vacca Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐Removal from State Dulaney Valley Mem Gardens: 10/25/07 Timonium Maryland ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityJohn O Mitchell IV Funeral Services of nature of Funeral S Dulaney Valley PA 200 Padonia Road East Timonium Md 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cordionyopany Year SCHEMIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerebrarascular page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wospica Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation Hospital or Attending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: יח 24 hou... the Funeral Direct. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTUSES 23 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles ST TONSON MD 21204 AMON J. CHANGES MO 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 3427

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	Diam'r.		Registrar 2	Reg. No. Date of Death  3. Time of Death					
-	Physicia ेव। Examii		Bethy Pearl Wathins	Month Day Year 0743 hrs					
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death					
			Bon Secours Hospital Baltimore		_				
	Funeral	$\neg$	5. Social Security Number 0. Sex	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign	- 1				
	Director		072.20.0255 1 M 2 XF 95 Yrs. Mollius 30,0 1000 1000 1000	09-10-1912   Country) VA					
		t	Usual Residence of Decedent	10d, Inside City Lin	mits				
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	and Shov	5	MD baltimore 106. Street and Number	10g. Citizen of What Country?					
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	2 hou "nat	ğ	Elementary/Secondary (0-12) College (1-4 or 5+)						
	36 thin 72 than than edical	Completed	19th Custolian	Lutheran Hospita					
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho re other traumatic event, the Medical Examiner must be notified at once.	S	17. Fattlet's Name (1 list, Middle, 2004)	First, Middle, Maiden Surname)	Ì				
	2121; uld be fil Mental F marked	Be	George Marshall Eliza	ral Route Number, City or Town, State, Zip Code)					
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	re, MD 2 s 1 and 2 shou f Health and M If item 27 is ner traumatic		1/ John Plage of Disposition (Name of cemetery	Date 20c. Location - City or Town, State	1				
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	Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other t		21. Signature of Funeral Service Licensee 22. Name and Address of Facility V Cure	ghn C reini lunerai gru tional Pithe baltimore Mis	794				
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or I	respiratory arrest, shock, or heart Approximate Int	erval				
	Physician Medical		failure. List only one cause on each line.	Between Onset Death	. and				
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	ician: s certi	&	examiner? Hospital: 1 Incation: 2 FR/Outpatient 3 DOA Other Nursing	g Home 5 Residence 6 Other:					
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	F 3 F S	₹		29d. Date signed (Month, Day, Year)					
	4		Josha Hell MD O.C.M.E.	October 22, 2007					
	0		30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
	7		Tasila Glocilotig Me. Theology	2 2 12 0 1					
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State Registrar CEUNARD

31. Date filed (Month, Day, Year)

RICH ARPSON

Registrar's Signature

M.P. 1838 GREENE TREE ROAP # 300 PLKESVILLE MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 34273 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Larry Wilkins **2**ඊීඊ7 6:40а м /Medical 4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice 4b. City, Town, or Location of Death Baltimore 4c. County of Death **Examiner** 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year) 7-19-1955 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 52 214-62-6655 N.C. **Director** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show; Medical Examiner must be notified at Md. NA Baltimore 1X Yes 2 No Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1800 E. Oliver Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than ' Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Disabled NA th and Mental Hygier 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be John Edward Davis Pecoria Wilkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trat once. Tracy M. Downs Sister 1800 E. Oliver St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Trinity Cemetery 4 Donation 5 Dother (Specify) 10-27-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Adenocarcinoma disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execut the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sate has been signed by the spage 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 1□ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D51788 10-23-2007 (MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

POLK MD

620

32. Registrar's Signature

Boulton St.

MD

Bel Air

**Physician** Williams Kim Miles /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner amethrounte Prysician Williams, Kim M. Date of Birth (Month, Day, Year) **Funeral** Days Min 217-78-3745 Director 10-26-1968 Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentul Hyglene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore NA Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 1127 Willinger Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XYes 2 □ No Yes, Give 'ear or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1∐Yes 2XNo Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phyllis Fleet Vernon မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1127 Willinger Ct., Baltimore, Md. Phyllis J. Williams-Whelchel 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 10-30-07 Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lan 1101 E. North Ave., Baltimore, Md. Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) monar **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, flam, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Little to (or an a consectuence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hear circuit has been circuit. Examin Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 1□ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last)

16b. Kind of Business/Industry Hotel Williams 20c. Location - City or Town, State Baltimore, Md. March F.H. East 21202 Approximate Interval Between Onset and Death unknown 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Lunknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**2.**No 2 No 1 □ Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Vamoryland Health Care System Perry Point, MD 21902

State Registrar 2 Accident

3∏ Suicide

29a, Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

M,U 32. Registrar's Signature

Marie Jacob

29c. License number

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

-22,2007

USA

14. Race - American Indian,

Black, White, etc.

Specify: Black

County of Death

Birthplace (State or Foreign Country)

Md.

10d. Inside City Limits

1X Yes 2 □ No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1734 P M 10 19 2007 Isabelle М. Willinghan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 2/14/1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F 69 232-60-1348 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medic I Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with is and Mental Hygiene.

Is marked other than "natural", or Items 23a or: 21144 USA 1901 Stone Hearth Ct. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Candy Company Office Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glen Cave Hattie Cutlip ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once. Mr. Albert Willinghan/spouse 1901 Stone Hearth Ct Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 10/26/2007 Crownsville 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Ameral Ser te Licer ee 22. Name and Address of Facility
Singleton Funeral & Cremation
1 2nd Ave SW Glen Burnie MD 21061
Srv M01364 Srvc Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Intracranial Hemorhage disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Uncontrolled Hypertension Sequentially list conditions, if any, leading to firm educate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician; The law requires that the death certificate be executed Systemic Inflammatory Response Syndrome 中.0. Box 68760, 中 burial-trar Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2∑ No 24a. Was an certificate has autopsy perfor 1 Yes mea≀ 2X No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1X Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 002 D64190 10/22/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital Dr. Rama Kapoor 1500 Forest Glen Rd Silver Spring MD 20910 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 2 5 2007

			For State Registrar	State of Maryla		artment of F rtificate of		/lental Hyg	eg. No. 2007	34276
4	Physicia /Medic	_	Decedent's Name (First, Middle, La GERALD	st)		WAXM	1AN	2. Date of Deat Month OCTOBER	Day Year	3. Time of Death 6:12 P
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of Dea	th
	for the second		800 SOUTHERLY ROA			TOWSON If Under 1 Year	Lift Index 04 Um	To by the		TIMORE
	Funeral Director			P Age (In yrs	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/19/1	916 9. Bir 916	thplace (State or Foreign ountry)
	land ow	Ì	Usual Residence of Decedent  10a. State 10b. County		ity, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	to	MD BALTII	MORE	TOW	SON				1 □Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	
	sath w	era	800 SOUTHERLY R		10	212			U.S.	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1	13.	was Decedent of F If Yes, specify Cub 1 ☐ Yes 2 🛣 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
Maryland 21215-0036	Ithin 72 ho le. lan "natul	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give		during most of work d)	king	16b. Kind of Business	·
2	filed w Hygier ther th		12 17. Father's Name (First, Middle, Last	1	OFFIC	E MANAGER	18. Mother's Nam	o /First Middle 4	INSURAN	CE
anc	Duld be fi Mental H arked ot atic ever	o Be	LOUIS	,	WAXMA	N	DORA	e (First, Miladie, i	naiden Surname)	COHEN
aryl	2 should be and Mental is marked ( aumatic ev	၉	19a. Informant's Name/Relationship (	Type. Print)				ral Route Number	; City or Town, State,	
	1 and 2 Health a em 27 is		CHARLOTTE WAXMAI					2 - TOWS	ON, MD 212	86
altimore,	Pages 1 nort of He int: If iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispo	osition (Name of matory or other pla	ce)		20c. Location - City or	
Ē	Pa ant:		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	(y) BP		E HEBREW  2. Name and Addre	i	•	REISTERSTO	
Ba	permit. Departi Importa any inji		Signature of Furieral Service Lice	No.	_			OL LEVIN: ROAD - I		INC. . MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. KENAL	FAILUR	26				
	Examiner			Due to (or as a conse	equence of):	(100	northy			
		ner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	iquento of):	1	PATAY			
14	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· PROSTA	1112	HYPER"	Trophy			
68760,	ificate be executed g physician and ts the burial-transit			Due to (or as a conse	equence or):	. ,				
687		edical		_d						
O. Box	The law requires that the death certifute has been signed by the attending vage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	blivery Day Year
Vital Records, P.O.	res that t signed by be detac	ρ	Part II. Other significant conditions	contributing to death but not re			ven in Part I.	23e. Did tol		to the cause of death?
202	v requ	Completed	147 = 1004 3 p	WOTE OF	TODICETT	CE				
Be	m (2) 01	dmc						24a. Was a autops perfori	prior to death?	utopsy findings available completion of cause of
ta		Be C	25. Was case referred to medical				26. Place of Dea	1  Yes th (Check only on	2 ☑ No 1 ☐ Ye	s 2 No
	Physical this ce al direc	임	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie	nt 3□ DOA Oth			ence 6 Other (Sp.	ecify)
Division or	Attending Physician: r death. ector: After this certifica by the funeral director,		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	w injury occurred	
Sic	or Attending Pefer death. Director: After the by the funera	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 280 Place of injury - At	home, farm, st		Yes 2 No	28f. Location (Si	reet and Number or F	Bural Route Number
2	a or /	Certification:	4 ☐ Homicide determined	building, etc. (Spec	cify)	, , ,		City or Towi		iaia/ riodio rvambol,
	To the Hospital or A within 24 hours after To the Funeral Direction Direction of the Funeral Direction by Manager 11 and 12 and 13 and 14 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and 15 and	edical (		nysician: To the best of my kr miner: On the basis of examin and manner stated.						
	To the within 2	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
	Λ			1		DI	9914		10/22	2/07
	4		30. Name and and ss of person who			Print) Alls K	S ST.	335	1 others	2/07 ille, Mo 21093
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		W: -	-, \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	. 601	CUME	1116, 19 4073
	Registr	ar	OCT 2 5 2007	Alexa D	4703					

Anthony D. Aitken State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 13, 2007 Medical Examiner 1939 hrs Anthony D. Aitken 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Atlantic General Hospital Worcester 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 8/25/1965 Country) MD 1 X M 2 217-68-8921 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f show Yes 2 X No VA St. Johns Potomac Falls Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20165 47123 Southhampton Ct. USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White etc. Yes 2 X No If Yes, Give Year Widowed Divorced Yes 2 X No specify: White Specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 72 If item 27 is marked other than "
If item 27 is marked other than " Baltimore, MD 21215-0036 ges I and 2 should be filed within of Health and Mental Hygiene. None None 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charle W. Aitken Mary Brummitt Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Aitken 24744 Harbor View Dr., Jacksonville, FL 32082 / mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Department of Important: I 10/14/2007 Frankford, DE Cape Henlopen Crem. Donation 5 Other Specify: 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medi\_al Death Cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical \_\_\_\_\_UNPENDED #23a,27,perME,g873, 11/15/07 TT attending physician or use as the burial Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknowr P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has 2 s death? performed? certificate | Yes 2 1 🗸 Yes 2 Nο the Hospital or Attending Physician: Ti nin 24 hours after death. The Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: Other; Inpatient 2 PR/Outpatient DOA Nursing Home 5 Residence 6 ဥ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural Yes 2 No Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 14, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month, Day Year) Registrar's Signature State 2007 Registra

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year HRM STRUNG Ch. 1038 R 2007 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 12/11/1921 Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 🕱 F 85 132-16-7855 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Anne Arundel Annapolis 1 ☐ Yes XX No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5303 River Crescent Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify White Specify: 3 ☐ Widowed ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Company Compensation Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph William Stock Gladys Esmeralda McGregor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30848 447th Ave. Mission Hill, SD 57046 Philip Armstrong Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 25 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10/9/2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease shock, or heart failure. e, by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) W. NG4 702 Due to (or as a consequence of): Chro p' o'm 2 0 5 2 2 2 1 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Natural Injury

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, t<u>i</u>

**Physician** 

/Medical

Examiner

Director

Funeral

9

Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

as use page 2

law requires that the death certificate be executed

Box 68760

P.0.

Division or Vital Records,

Examiner y physician and as the burial-transit Physician/Medical attending the n signed by th \$ Completed peen has certificate Be After this of P Certification: hours after death, Director: a ho iin 24 hours. **"Ne Funeral Dir.** "v filled in bv

the Hospital or Attending Physician: within 2

29b. Signature and title of certifier Anthony

OCT 1 0 2007

6 Could not be determined

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arkway aputo medi 31. Date filed (Month, Day, Year, egistrar's Signature

t 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 ☐ Yes 2 ☐ No

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 14 2007 ear Bernadette Jane Arnold 12:05PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 96 Poplar St. Westernport Allegany If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | June 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F <sup>4</sup>1950 218-62-6596 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural, or itama 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Allegany Westernport 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 185, Dans Mountain 21562 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yoo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 12 permit. Pages 1 and 2 should be filed Depertment of Heelth and Mental Hygis Important: if itsm 27 is marked other t any injury or other traumatic avant, in other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Clark Elva Jane Johnston ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luther Arnold/ husband PO Box 185, Dans Mountain, Westernport, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Westernport Maryland Philos Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7 Wans 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arian /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Tiesees of Jury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š is certificate hes been sign director, pege 2 should be 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only on spital: 1 Inpatient 2 | 28a. Sate of Injury (Month, Day Year) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of D ath 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending efter death.
Director: Af Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funers! L Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Norman Wood, 17204 McMullen Hwy, Cresaptown, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

1.8

2007

State of Maryland / Department of Health and Mental Hygieneo 34280 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Oct **Physician** JEFFERY C. BARBER 1152 M 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kegional Medical ( alesbury Wiconeco If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–30–1951 rs. last birthdav 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. DELAWARE 221-40-5929 55 Yrs Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director SUSSEX FRANKFORD DELAWARE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? h and Mental Hygiene. 7 Is marked other than "natural", or items 23a or : traumatic event, the Medical Examiner must be n 19945 **#4 CLAYTON AVENUE** US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE WORKER POULTRY INDUSTRY h and Mental Hygien 7 Is marked other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be HAYWARD BARBER FRANCES O. MILLETT ္က 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4 CLAYTON AVE, FRANKFORD, DELAWARE. 19945 permit. Pages 1 an
Department of Healt.
Important: If item 27
any Injury or other tra PATRICIA A. BARBER/ WIFE 20b. Place of Disposition (Name of MELSONS CAPE HENLOPEN CREMATORY Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 10-11-07 FRANKFORD, DELAWARE 21. Signature f Funer MELSON FUNERAL SERVICES, LTD.
43 THATCHER ST, FRANKFORD, DELAWARE. 19945 23a. Part1. Enter the diseashock, or heart failure
Immediate Cause (Final disease or condition resulting in death) e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vea Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate l 1 Yes 2 No 2□ No Hospital or Attending Physician: funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation Injury death. 1 🗌 Yes 2 □ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated. 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name a ed cause of death (Item 23a) (Type, Print) address of person who comple BA 5 MOU ed (Month, Day, Year) State 2 2007 OCT 1 Registrar

			For State of Ma State Registrar		epartment of He Certificate of D		lental Hyલ -	giene	34281
			Registrar  1. Decedent's Name (First, Middle, Last)		er timeate or E	Calli	2. Date of Dea		3. Time of Death
	Physicia						Month October	8, 2007 Year	12:20 A M
	/Medic Examin	-	John Frederick Bendermeyer  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or		0020001	4c. County of Dea		
	LAGIIIII	Ci	Anne Arundel Medical Center		Annapoli	S		Anne Aru	nde1
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v. Year) C	rthplace (State or Foreign ountry)
	Director		210-32-1770	71 Yrs	S		March 2	4, 1936 Ma	ryland
and	*		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
Mary	f sho	ō	Maryland Prince George's	Bowie					1X1Yes 2 □ No
the	notif	Director	Maryland   Prince George's   10e. Street and Number	DOWIE	10f. Zip Code			10g. Citizen of What C	ountry?
h with	3a ol		3909 New Haven Court B-3		20716			USA	
deat	er mu	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp.	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh	
after	or ite		1 □ Never Married 2 💹 Married 1 □ Yes 2 🖼 N		1 ☐ Yes 2 🗓 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specific	
Suor	uraľ", il Exe	d by	3 Widowed 4 Divorced Year or Dates:	160 D	ecedent's Usual Occupa	ation		16b. Kind of Busines	ite
72	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)		Give kind of work done of ife. DO NOT use retired	luring most of work )	ing		
with A	iene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5-	F)	lder			Potomac In Engineer	
filed	other ent, i	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surname)	
d bi	lenta rked tic ev	To B	Herman P. Bendermeyer			Evelyn A	. Baker	:	
a y	s ma		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street a				•
and 2	Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at	1	Adrian Bendermeyer/ Wife		9 New Have				
Ses 1	or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	cemetery,	Disposition (Name of crematory or other place	e) :	Date	20c. Location - City of	r Iown, State
. Pa	tmen tant: jury		4 □ Donation 5 □ Other (Specify)	MeCre	politan ematory		/2007	Alexandri	
Dermi Dermi	Department of Health and Mental Hygiene. Important: If Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	. 8	21. Signature Funeral Service Licensee					Evans Fune Le, MD 2071	
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do no					Approximate Interval Between
PI	nysician	å v	Immediate Cause (Final disease or condition	C	CADD				Onset and Death
	Medical		resulting in death)	a consequence of	):				
E	xaminer	_	Sequentially list conditions, b.						
pe	ısıt	nine	cause. Enter Underlying	a consequence of	,.				
, xecu	and al-trar	Examiner	Cause (Uisease or injury that initiated events resulting in death) Last C	a consequence of	):				
orou,	physician and the burial-transit	dical E	d						
filicat	g phy as the	ledi							
The law requires that the death certificate be executed	been signed by the attending is should be detached for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	pf pregnancy 2 □ Fetal death	3 □Ectopic pregnancy	,		23d. Date of c	
o dear	he att	sici	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at		5 ☐ Other (specify) _			Month	Day Year
T ter	d by t letach	Phys	9 ☐ Unknown  Part II. Other significant conditions contributing to death but	it not resulting in t	he underlying cause giv	en in Part I	23e. Did	to - cco use contribute	to the cause of death?
ires t	signe I be d	b	Tarri. Oaler significant conditions continuously to document	action roodining in t	and an action you		100		Probably 4 Unknown
law requires	peen	etec					24a. Was	an / 24h Were	autopsy findings available
בי קו פי	has ge 2	Completed					auto perf	ppsy prior t ormen? death	o completion of cause of ?
VIIAI	ificate or, pa		25. Was case referred to medical			26. Place of Dea	th (Check only	27 No 1 □ Y	es 2 No
Vsicis	is cert direct	To Be	examiner?  1 Yes 2 No Hospital: Inpatie	nt 2 ER/Outp	patient 3 DOA Oth	or:		idence 6 □Other (Si	pecify)
5 4	ter thi		27. Mann of Death 28a. Date of Inju		me of 28c. Injur	y at k?	28d. Describe	how injury occurred	
IVISION TAffending	or: Af	atic	2 Accident investigation			Yes 2 □ No			
JIVIX or Att	Olrect Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injubuilding, etc.	ury - At home, farn c. <i>(Specify)</i>	n, street, factory, office		28f. Location ( City or To	(Street and Number or own, State)	Rural Route Number,
T istle	ours a		29a. Certifier 1 Certifying Physician: To the best	of my knowledge.	death occurred at the til	me, date and place	e, and due to the	e cause(s) and manner	as stated.
H d	within 24 hours after death.  To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s	Medical	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and					
Ę	within To the comp	Me	29b. Signature and Affle of Certifier	^-	29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	Fr fo	1	> N JUNUL	in p	100	5847		10/0	1/2W/
	1/6	X	La VVCIND)	eath (Item 23a) (T	ype Print) R	d11-17	Ave	Anni	och, sop
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 0 2007	ar's Signature	Soul ,	0 /		· /	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34282 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician a.™ Roger William Bartelt 10/08/2007 5:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F 70 230-46-2061 Director 05/30/1937 Washington, D.C Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Maryland Prince George's Lanham 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5516 Belva Street 20706 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 56-62 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ò Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Financial Director Travel Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Abbott Bartelt Katherine Irene Cross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardith Bartelt/wife 5516 Belva Street, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemelery, crematory or other place)
Maryland Veterans
Cemetary 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott
once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2007 | Cheltenham, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WEEKS om /Medical Due to (or as a consequence of): Examiner 10 toxcycl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Box 68760, attending physician pe Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2₽No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 1∐Yes 2∐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2 No 1 Inpatient 2 Proutpatient 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: 5 ☐ Pending investigation Injury 1 Natural 409 1 ☐ Yes 2 Accident hin 24 hours af er death the Funeral Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. FH035392 To the within 2

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

HEVERIG MO 3078

State of Maryland / Department of Health and Mental Hygiene 2 For AMEND#17 Per FH State of ividity and State Registrar AMCO HEALTH DEPT. CMH 10/10/07 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BROWN ILCI AN 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1701 Wells St. Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 2 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 F 1927 Maryland 213-22-0035 80 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. Count 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 902 Spa Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or Health any Injury or other treasment. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Specialist A Federal Government 2vrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joh<del>n McGowam</del>- John McGowan Nola Gardner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Washington(Daughter) 2085 Ingleside Ct. Crofton, Md. 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 10-15-07 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Manusme Reverses of EaciliSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 11,1 Jeen MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 4 Rec disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3□ DOA 6 Other (Specify) Certification: To Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident Injury 5 ☐ Pending RESIDENTAL 1 ☐ Yes 2 ☐ No investigation Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō To the Hospital or within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and tit nleted cause of death (Item 23a) (Type DEFENSE HIGHWAY ANNAPOLIS MONIGOI MICATAL 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 0 2007

State of Maryland / Department of Health and Mental Hygiene 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:15 PM October 14, 2007 Maggie F. Butler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Beverly Living Center Cumberland If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** F Months 188-22-3868 96 Maryland Apr 14, 1911 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d, Inside City Limits 10h County "naturai", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 640 Hill Top Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 Widowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lily Mae Fauzy ဥ Harrison Fuller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if item 27 is ury or other trau 640 Hill Top Drive, Cumberland, MD 21502 Kathleen McKenney/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page:
Department of
Important: If I
any injury or Salisbury Cemetery Oct 17, 2007 Salisbury, PA 21. Signature of Funeral Service Licensee Name and Address of Facility Homes, P.A., P.O. Box 275 emace 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Athero slente Cardioverder /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any cause of the Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy page certificate 1∏ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attending 1. Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 18,2W7 D-0036766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-777-5456 Vikramaditya Poonai, M.D., 924 Seton Drive, Suite 2, Cumberland, MD Registrar's Signature 31. Date filed (Month, Day, Year)
OCT 1 9 2007 State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007

			1 - State Registrar	,	Cer	tificate	of Death	F	Reg. No.		04200	
	Physicia		Decedent's Name (First, Middle, La Gloria	Yvonne Bosle	≘y			2. Date of Dea Month	Day	Year	3. Time of Death 3:30 P M	
	/Medi Examir		4a. Facility Name (If not institution, give street and number)  30 Patterson Ave.			4b. City, Town, or Location of Death Bloomington			4c. County	4c. County of Death Garrett		
	Funeral Director		5. Social Security Number 214–42–0334 6. Sex 1 M 2CXF 7. Age (In yrs. last birthday, 65 Yrs.			y If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Month, Day, Year)  Jan. 5, 1942    Maryland   M					itry)	
	n 72 hours after deeth with the Maryland "natural", or Itema 23a or 28a-f ahow Edical Examinat must be notified at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li							0d. Inside City Limits		
		ai Director	30 Patterson Ave.				04-0-0			n. Citizen of What Country? Inaited States		
960	ours after dee ral', or Itema Examinar m	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Vas Deceder Yes, specify	nt of Hispanic Origin? (S r Cuban, Mexican, Puer I No Specity:	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, fy: Whi	etc.	
21215-0036	C _ @	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Deced (Give I life. D	ent's Usual ( kind of work of OO NOT use	Occupation done during most of wo retired)	rking	16b. Kind of B	lusiness/Inc	dustry	
	should be filed withind Mental Hygiene.  I marked other ther umatic evant, Ira M	Comp	Elementary/Secondary (0-12) unknown	College (1-4or 5+)	Homemaker						lousework	
Maryland		To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Model in a Name (First, Middle, Maiden Surname)									
Mary			19a. Informant's Name/Relationship (Type, Print)  Donna Martin/ daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Rt. 1, Box 173, Elk Garden, West Virginia 26717									
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth a Important: If Itam 27 is any injury or other tra QDGE.		20a. Method of Disposition i 2 Burial 2 □ Cremation 3 [	20b. Pla	ice of Dispos	sition (Name	of er place)	Date /21 /	20c. Location	- City or To		
Balti	permit. P Depertme Importan any injur		21. Signature of Funeral Service Cicensee  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility									
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.									
.O. Box 68760,	To the Hospital or Attanding Physician; The law requires thet the death certificate be executed by Within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sue to (or as a conseque  c	ence of):	List.	ush	Algorian Contraction of the second	mu	7	10tgra	
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)						ate of delive	ery Day Year	
rds, P.		þ	Part II. Other significant continuous continuing to death but not resulting in the underlying cause given in Part I.									
i Records,		Completed								Were auto prior to cordeath?	psy findings available mpletion of cause of	
of Vital		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
of		Certification: To	1 Yes 2 No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing				Home 5 € Residence 6 □Other (Specify)  28d. Describe how injury occurred				
			1 Statural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28c. Injury at Work?  M 1 Yes 2 No		28d. Describe h	low injury occu	rred			
Division			3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital within 24 hours e To the Funeral Completely filled	edicai	29a. Certifier (Check only one)  1	hysician: To the best of my know miner: On the basis of examination and mapping stated.	rledge, death on and/or inv	occurred at restigation, in	the time, date and place my opinion, death occu	e, and due to the curred at the time,	cause(s) and m date and place,	anner as si and due to	ated. the cause(s)	
	To t To t com	M	29b. Signature and title of certifier	108/85 - 0.2 18, 200 ?								
		2	30. Name and address of person who Dr. Robert Bess,	completed cause of death (Item 2 , 122 Ashfield S	23a) (Type, F St, Pie	edmont	, WV. 26750	)	-			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	e A A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October By, 20Ŏ<del>7</del> Regina Marie Bouchard 12:50 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 8. Date of Birth
(Month, Day, Year)
Sept. 27, 1918 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 F 89 578-54-7247 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits 1 ☐ Yes 2 XNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3711 Kenway Street 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No <sup>Specify</sup>.White Specify. 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Gordon Brocator Marie Ambrose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Altomare/Granddaughter 3711 Kenway Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 2007 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or omblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 2 No 3 Probably 4 ☐Unknown

**Physician** /Medical Examiner certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

with

death

filed within 72 hours after Hygiene.

"natural"

other than

h and Mental h 1 and 2 should be

permit. Pages 1 and 2 s.
Department of Health an
Important: If Item 27 is i

the Medical

traumatic

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner burial-trar attending physician Physician/Medical the as ase for the detached signed by t þ Completed page 2 s nas certificate Be ို

this : After t or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. To the Hospital within 24 hours a

Certification:

Medical

State

Registrar

Division or Vital Records, P.O. Box 68760

		COLOR DE LA CONTRACTOR DELA CONTRACTOR DE LA CONTRACTOR DE LA CONTRACTOR DE LA CONTRACTOR D								
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ∑No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5□Residence 6型Other (Specify)Hospice								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work?	8d. Describe how injury occurred								
3 Suicide 6 Could not b 4 Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre									

29b. Signature and title of certifier 20

29c. License number D64615 29d. Date signed (Month, Day, Year)
October 8, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

2007

31. Date filed (Month, Day, Year) 10 32. gistrar's Signature

and manner stated



Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 has been signed by the a je 2 should be detached i certificate or Attanding Physician: : After this certifical funeral director, within 24 hours after deat To tha Funarel Director: filled in by

**Physician** 

/Medical

Examiner

10a. State

Director

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Examine

Physician/Medical

Funeral

Director

itam 27 is marked other than "naturel", or Itams 23a or 28e-f show other traumatic avant, the Nedical Examinar must be notified at

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "naturel", or Ital

itam 27 i

Importent: If its any injury or other

Physician /Medical

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Nnknown à

Completed 25. Was case referred to medical examiner? Be Hospital: 1 Impatient 2 1 🗌 Yes 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Ceath 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier RES-000 MEDICAL DOCTOR

29c. License number 29d. Date signed (Month, Day, Year)

October 06 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOYCE L. SAUCHEZ, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, Baltimore, MD 21287 31. Date filed (Month, Day, Year)

State Registrar

Medical

OCT 1 0 2007



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4, 2007 October 5:05 Rose Bergman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Maplewood Park Place Bethesda 8. Date of Birth (Month, Day, Year) 11/29/1913 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex Funeral Months Days Country) Hours 1 ☐ M 2 😾 F 93 073-38-8634 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 ☐Yes 2 ☐ No Director Bethesda Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be r US 9707 01d Georgetown Rd. #107 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☑ No Specify Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mollie Thaler Fuchs Samue1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Starview Court Potomac, Md. 20854 12008 Eric Bergman/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Park Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 10/7/07 Hudson, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Failure To Thrive Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Dementia that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2√ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 1 No 1□ Yes 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ဥ after death.

Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/5/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Pfint)
Dr. Merlyn Vemury 9801 Georgia Ave. Suite 227 Silver Spring, Md. 20902

State Registrar Dr. Merlyn Vemury

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2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

MELLES

07-07952		Please Type or Print in Black Indelible Ink. Ensure All C	Copies Are	e Legic	oie.	107	34289	
Allen Beckwith	1	State of Maryland / Department of Health and Men  -For State Certificate of Death	itai riygien			301	3420.	
Physicia	F	tegistrar  1. Decedent's Name (First, Middle,Last)	2. Date	Reg. I		3. Time	of Death	
Physicia Medical Examin		ALLEN E. BECKWITH		ber 11, 2			2 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location	of Death		4c. County of D Frederick	Peath		
		Frederick Memorial Hospital Frederick  5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under	ier 24Hrs. 8. Da	te of Birth/N		. Birthplace (S	State or	
Funeral Director		Months Days Hour.	rs Min.		)F	oreign	MD	
Diver to:	-	215-38-3202 1 XM 2 F 64 Yrs.	1 100	t.4,	1943		MD	
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location					side City Limits	
<u> </u>	_	MD Montgomery Germantown		1 XYes 2 No				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What	Country?		
vith the Mary s 23a or 28a e notified at		17544 Black Rock Road 2087			U.S.		n Plack	
h with	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Or  Armed Forces? Ukn  14. Was Decedent of Hispanic Or  If Yes, specify Cuban, Mexica	rigin? ( Specify Yo an, Puerto Rican,	es or No- etc.)	14. Race - / White, e	American India etc.	an, black,	
r deat or ite	뒤	1 Yes 2 No specify  Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify	v:		Specify:	Black		
rs afte ural",	<u>a</u>	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	e kind of work dor	ne 1	6b. Kind of Busin			
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	11 use retired)					
036 ithin ane.	Completed	12th Carpenter	- I I I I I I I I I I I I I I I I I I I	Middle Me	Const	ructi	on	
5-0 filed w Hygie d othe		17. Patrier S Name (First, Middle, 2007)	er's Name (First, Anna Ra					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	o Be	Wesley L. Beckwith  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No.				State, Zip Co	de) 2085	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medie-I Examiner.		Elizabeth B. Adams (Sister) 711 N. Stor	nestree	t Av	e., Ro	ckvil	le,MD	
e, M l and 2 Health a item 2	3 - 1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	- !	20c. Location - C	City or Town, S	State	
nor ages ent of nt: If		John Wesley Cem			Clark			
Baltimore, permit. Pages I at Department of He Important: If ite injury or other to		21 Sinnatuse of Funeral Service Acensee 22. Name and Address of Facility						
E F C F C		Several K. Amwalin S. 246 N. Wash					oximate Interval	
Physician /Medical	ΠĬ	failure List and one cause on each line.	o cardido or roopii		,	Betv	veen Onset and Death	
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):		_				
		b						
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
0	ami	Clisease or injury that initiated events resulting in death) Last over the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro						
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	dical	X UNPENDED AMENDED 4.27, perME, g872, 10/29/07 TT			Tan B (	1.17		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	opic pregnancy		23d. Date of o Month	Day	Year	
c 68 certif ending use as	ciar	past 12 months?    4   Pregnant at time of death   5   Other (Specify)			in the		10	
Box death the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown	5.0	220 Did tab	acco use contril	oute to the car	ise of death?	
P.O. es that the igned by the detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.		2 No 3			
S, P uires t n sign Id be	<del>g</del>			24a. Was a			indings available	
ord  w req as bee	Completed			autops perform	n <u>ed</u> ? d	eath?	tion of cause of	
Rec The la icate h	ह			Yes 2	No 1	<b>✓</b> Yes	2 No	
cian; certif ector,	B B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4	ath (Check only o		Residence 6	Other:		
Division of Vital Records, ral or Attending Physician: The law require rs after deam. After this certificate has been si led in by the funeral director, page 2 should b	<u>۽</u>	27. Manner of Death  28. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at W			ow injury occurr	ed		
on o nding th. r: Aft	<u>:</u>	1 X Natural 5 Pending 1 Yes 2	No No					
iSiC r Atter er dea irecton	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building		Location (S or Town, St		er or Rural Ro	ute Number, City	
Div nital or urs aft rral Di	Certification:	4 Homicide determined (Specify)						
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	<u>                                   </u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	d place, and due to	to the cause	e(s) and manner and place, and d	as stated. ue to the caus	se(s)	
To the within To the	Medical	and manner stated.			29d. Date sign			
	Σ	29b. Signature and title of certifier  O.C.M.E.			October 12			
		Milss						
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, March 23 (Item 23a)	MD 21201					
9	tate	31. Date filed (Meeth Sey, Year) 0007 32. Segistrar's Signature		-	-			
Regis		UCT 19 2007 Bloques for Appen						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $2 \, \cap$ Certificate of Death 2. Date of Death Month Year Physician Ernest Wayne Bowman atober 03 Z007 /Medical 4c. County of Death 4a. Eacility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner illista Medical Center Charles Plata La If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** 11 M 2□F Director May 30, 1944 230-56-7366 Clover, VA 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at TELYes 2 No Director Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 11101 Brandywine Road 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married **Black** 1 ☐ Yes 2 No by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than, College (1-4or 5+) Warehouse Employee Private Important: If Item 27 is marked other any Injury or other traumonia. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Edward Bowman Josephine Craddock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Denise Bowman - Daughter 7101 Branchwood Pl. Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Matt Bapt Ch Cemt Oct 12, 2007 Clover, Virginia St. 21. Signature of Funeral Servi 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock is heart failure. List only one cause on each the Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, loading to in modat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a co attending physician for use as the hirial Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 Ves 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contribe g to death but not resulting in the underlying cause þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was an has page 2 autopsy perform this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

be executed Box 68760, Physician:

Maryland 21215-0036

Baltimore,

P.0. Division or Vital Records,

or Attending

within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Certification: Medical State Registrar

၉

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifie

30. Name and addr of part in who completed cause of death (Item 23a) (Type, Print) Song C. Chon M.D 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

Censa Medical Center 70 Post Office Road Walderf, MD 2002 32. Registrar's Signature

1 patient

(Month, Day Year)

28a Date of Injury

2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Mohth. Dav. Year)

28h Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 October 9:55 P M Henry John Bottner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 2505 Mill Branch Road Bowie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 □ F 9, Sept 1918 Director 217-36-7618 89 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Md. Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 20716 USA 2505 Millbranch Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2X No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Agriculture 5 item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be should be Viktoria Gschwend Heinrich Bottner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2: permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauguse. Mary Bottner - Wife 2505 Millbranch Road, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10-10-te-07 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, Maryland Lakemont Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 6512 Crain Hwy. Bowie, Mt. 20715 21. Signature of Funeral Service Licensee Beall Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ladder carcinoma **Physician** 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the 88 ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No The law has autopsy page performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours a er

Records, P.O. Box 68760, Division or Vital

altimore, Maryland 21215-0036

within 24 hours at To the Funeral D completely filled or To the Hospital if

Medical

Alain G. Champaloux, OCT 0 9 2007

29b. Signature and title of certifie

(Check only

14314 Old Marlboro Pike M.D. 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Upper Marlboro, MD. 20772

34292 Linda A. Coale State of Maryland / Department of Health and Mental Hygiene 2007 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day October 8, 2007 Year Linda A. Coale 0357 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min. Director 217-08-4478 35 4/11/1972 Country) 1 M 2X F MD Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XX No MD Anne Arundel Crownsville Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other trannatic event, the Medical Examiner must be notified at once. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 933 Buttonwood Trail 21032 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 X Married Divorced If Yes, Give Year 4 3 Widowed Yes 2 X No specify: Specify. White \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Supervisor Electrical Contractor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Shipley Be Sara Cooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Coale Husband 933 Buttonwood Trail Crownsville, MD 21032 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Glen Haven Cemetery 10/12/2007 Glen Burnie, MD Donation 5 Other Specify 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jure of Feneral Strvice Licensee 12 Ridgely Ave. Annapolis, MD 21401 【 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval art I. Ente the dise **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) b. Left iliac vein thrombosis Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical signed by the attending physician I be detached for use as the burial UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Sep 27, 2007 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ Records, P. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? r this certificate had director, page 2 Yes 2 1 V Yes No 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Be of Vital Hospital: 1 Other; DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 Residence 6 1 Yes No After the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Division Yes 2 No Pending Fo the Funeral Director: the Investigation Accident completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide ca Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 9, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

07-07845

ORIGINAL

			For State	State of Marylar	-			Mental Hyg	iene	34294
			State Registrar		Ce	rtificate of	Death	2. Date of Deat	g. N <del>b.</del>	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, La.  JAMES		ren en			Month October	Day Year	
	/Medic	0.0	4a. Facility Name (If not institution, give	HUGO CARPENT	iek, sk	T	or Location of De		4c. County of Death	6:19 A M
	Examin	er	Washington Adve		L	Takoma			Montgome	erv
8 -3	Funeral	2	Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)		If Under 24 H			nplace (State or Foreign
Ž.	Director		376-30-3930	¥ M 2□F 64	Yrs.			09/23/4	3 Wash	ington, DC
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary Ist	tor	Maryland Montgom	ery Si.	lver S	Spring				1 X Yes 2 No
	th the	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ıntry?
	ath wi	raic	10875 Lockwood 1				20901		USA	
	hours after death with the Maryland Lural', or Items 23a or 28a-f show at Exeminer must be multiled at	Funeral	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Amer Black, White	e, etc.
5	urs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Tyes 2 □ No If Yes, Give 1967 Year or Dates: 197	_	1 ☐ Yes 21 No	Specify:		Afric Specify: Ame:	can rican
9500-61212	"natural",	Completed by	15. Decedent's Ei (Specify only highest gra	ducation	16a. Dece	dent's Usual Occu	ipation	working	16b. Kind of Business/I	ndustry
7	는 . c d	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	9d)		C-16 E1	1
	be filed within 72 htal Hygiene. od other than "nai event, the Medic	Cor	17. Father's Name (First, Middle, Last,	3		mputer T		an Name (First, Middle, M	Self Emplo	oyea
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Maryland	should nd Me mark mark	우	19a. Informant's Name/Relationship (		_		1		, City or Town, State, Z	
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		James Hugo Carpe	nter, Jr. (Son	) 9300	Cherry	Hill Rd	.,#203 - C	ollege Parl	k, MD 20740
or G	m Q b	- 3	20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐	Removal from State	Place of Disponentary, cre	osition (Name of matory or other of ale Park	ace)	Date	20c. Location - City or	Town, State
Ě	nit. Pages artment of lortant: If it injury or o		4 □ Donation 5 □ Other (Specif		Cremat	orv	10	/13/2007	Riverdale	, MD
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Fundal Service Uter	nsee /		2. Name and Addi	•		eral Servi	
			23a. Part1. Enter the disease, or comshock, or heart failure. Little and	olications that caused the dea					hington, De	Approximate
			shock, or heart failure. List fily Immediate Cause (Finat	one cause on each line.  Atherisch	contro	Cavalo	I A	week c	100000	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		Corse	477	1030.7 (	, (36)	
9	Examiner		Same attacks for a self-time.	b						
	D 118	Iner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):					
_	be executed sicien end burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a conse	auence of):					
9/	ysician ysician	calE		,	,					
9				_ u.						
ROX	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		⊒Ectopic pregnan	cv		23d. Date of deli	,
	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)	-,		Month	Day Year
J Ö	The law requires that the death certifica sie has been signed by the attending ph sage 2 should be delached for use as th		9 ☐ Unknown  Part II. Other significant conditions of		sulting in the I	ınderiving çause o	wen in Part I	23e. Did to	bacco use contribute to	the cause of death?
Records,	signe d be	d by	, and a significant contains	is in the second second second re-	3311119 1110 1	moonying occors			es 2□No 3□Pro	5
Sor	w require been si should t	Completed						24a. Was a	n 24b. Were au	topsy findings available
Ř	The law sete has page 2 s	dmo						autops perfori	sy prior to or med? death?	completion of cause of
Vital	iclan: Th certificete rector, pag	0	25. Was case referred to medical				26. Place of I	Death Check only on		2810
<u>&gt;</u>	ding Physician: h. After this certific funeral director,	To B	examiner?	Hospital: 1 Inpatient 2	EP Outpatie	nt 3 DOA	then 4 Nursin	g Home 5 Reside	ence 6 Other (Spec	cify)
ב	ing P		27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ork?	28d. Describe ho	ow injury occurred	
Division of	i or Attend after death Director: /	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 200 Blace of Injune At I	home farm si		Yes 2 □No	28f. Location (S	treet and Number or Ru	ıral Route Number.
2	after Direct	Certification:	4  Homicide determined	building, etc. (Spec	ify)	reet, lactory, office		City or Town	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,		29a. Certifier Certifying Pl	nysician: To the best of my kr	nowledge, dea	th occurred at the	time, date and pl	ace, and due to the c	ause(s) and manner as	stated.
	the Hin 24 the Fu	Medical	one)	niner: On the basis of examinand manner stated.	ation and/or ii					
	To Toon	2	29b. Signature and title of certifier	Ly Z TIL 3	e h. M		326	2	29d. Date signed (Monti	
14	911		7	1 Jugar			. ,		10/4/20	07
(	1)4-1		30. Name and address of person who	completed cause of death (Re			Carro1	Ave. Tak	oma Park. N	1D 20912
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	naty e	,				
1 × 28	Registr	ar	nrt n 9 2007	179. 1. in 1	July 1					

			State of Maryland / Department of Health and Mental Hygiene 2007 34295  1- State Remove #28c per PHYS 10-12-07 CNM Registrar Remove #28c per PHYS 10-12-07 Certificate of Death  Reg. No.
· ·	Physici		1. Decedent's Name (First, Middle, Last)  Gerard Robert Donovan JR  2. Date of Death Month Day Year October 2, 2007  6:01 P <sup>M</sup>
Ì	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. Anne Arundel
	Funeral Director		5. Social Security Number 219-40-2674 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. May 1.
	Maryland f show led at	or	Usual Residence of Decedent  10a. State
	n with the l 3a or 28a- st be notif	al Director	10e. Street and Number 802 Whitewood Trail 10f. Zip Code USA
36	J within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 23a-f show the Medical Examiner must be notifled at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 □ Yes 2 No Specify: Specify: White
21215-0036	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) environmental protection specialist  16b. Kind of Business/Industry federal government
	ild be filed lental Hygi ked other Ic event, tl	To Be Co	12 specialist government  17. Father's Name (First, Middle, Last) Gerard Robert Donovan Sr. Kathryn V. Link
, Maryland	ges 1 and 2 should be filed t of Health and Mental Hyg If Item 27 is marked othe or other traumatic event,		19a. Informant's Name/Relationship (Type. Print) Ruth Ann Donovan (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Whitewood Trail, Crownsville, MD21032
altimore,	Pages 1 ament of He lant: If Item		20a. Method of Disposition  1 Sulface of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Smithsburg Crematory10/3/07 Smithsburg, MD
Bail	permit. Page Department of Important: If any injury or once.		21. Frather of funer Service Hoofie  21. Dome and Address of Familian pson Funeral Home P. O. Box 18, Middletown, MD 21769
	Physician /Medical	/	23a. Part / Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  GAURIAT DAR CANCER
	Examiner	er	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):
68760,	ficate be executed physician and is the burial-transit	al Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or light, that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):
Box	ath certii aftending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   9   Unknown   9   Unknown   23c. If yes, outcome pf pregnancy   23d. Date of delivery   23d. Date of delivery   Month   Day   Year   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9
rds, P.O	quires that the de n signed by the a uld be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown
Heco	The ate ha	Completed	24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   1   Yes 2   No
or Vital Records,	g Physiclan: The er this certificate eral director, pag	To Be	25. Was case referred to medical examiner?    Continuous case referred to medical examiner?   Hospital:
DIVISION	or Attending Futer death.  Clrector: After in by the funers	Certification:	1 ☐ Natural 5 ☐ Pending investigation 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide 4 ☐ H
2	Hospital 4 hours a Funeral I	ledical Ce	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the complete	Med	29b. Signature and title of contifier  Physician MD DooGu507  29d. Date signed (Month, Day, Year)  /// Ciglow 7
Ì	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta Regist		Nationish Panoga, ND 22 S. GREENE ST Ru 59044C Bremone Mid 21201  31. Date filed (Month, Day, Year)  OCT 1 2 2007  OCT 1 2 2007

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

		For State of Maryland / Dep	artment of Health and		giene 2007 34296 Reg. No.
		Decedent's Name (First, Middle, Last)		2. Date of De	ath 3. Time of Death
Physicia /Medic		Alan Park Davitt		Octobe:	r 8, 2007 2:00 P M
Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Death
		Homestead Villages  5. Social Security Number	Germantown ) If Under 1 Year   If Under 24 H	Hrs. 8, Date of Bir	Montgomery  th 9. Birthplace (State or Foreign
Funeral Director		229–36–1893   18 M 2 F   74   Yrs.		Min. (Month, Da May 13	(Country)
p		Usual Residence of Decedent			
arylan show d at	7	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M 28a-f lotifie	Director	MD Montgomery Rockvil  10e. Street and Number	1.e 10f. Zip Code		10g, Citizen of What Country?
with sa or	اق	16600 Baederwood Lane	20855		United States
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, P	(Specify Yes or No	
or ite		1 Never Married 2 Married 1 Yes 2 No 1934-	1 ☐ Yes 2X No Specify:	acro moan, c.c.,	Specify: White
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene with matural, or items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates: 1937	edent's Usual Occupation		16b. Kind of Business/Industry
in 72 in 72 in 72 ledica	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of DO NOT use retired)	working	Not. Kind of Business/madsay
yiene.	mo	Elementary/Secondary (0-12)  College (1-4or 5+) 5+  Ac	countant		Accounting
al Hyg	Bec	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First, Middle	, Maiden Surname)
y and bould to Ment	2	Daniel Joseph Davitt		abeth Moo	
VICAL VICAL VISION TISION Traum		1	ling Address (Street and Number o		er, City or Town, State, Zip Code)
Healt Healt tem 2		20a Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		11 I Rurial 2 & Cromation 31 IRomoval from State 1	itan Crematory 0	ctober 9   2007	Alexandria, VA
mit. F partm portar y Injui					eral Home
			O East Deer Park	Drive Ga	ithersburg, MD 20877
		231. Part1. Ent r the disease, or complications that caused the death. Do not e shock, or leart failure. List only one cause on each line.	nter the mode of dying, such as car	rdiac or respiratory a	rrest, Approximate Interval Between Onset and Death
Physician		regulting in death)	Cardiovascular	Disease	
/Medical Examiner		Due to (or as a consequence of):			
\$ P	er	Sequentially list conditions, if any, leading to immediate b. Pmeumonia  Due to (or as a consequence of):			
outed ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
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The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
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t the c	Physi	9 ☐ Unknown			
res that the de signed by the a	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute to the cause of death?
w require				_   1⊔	Yes 2 No 3 Probably 4 Unknown
e 2 sh	Completed			— 24a. Was	
	_			1□ Yes	2 ဩxNo 1 ☐ Yes 2X No
or Attending Physician: The law after death death. In the thick the function of the function of the funeral director, page 2 s in by the funeral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ XNo Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati		Death (Check only	<sup>one)</sup> idence 6 ⊠Other <i>(Specify)</i> Stay Hote1
5 £ ##	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe	how injury occurred
endin Pr: Aff	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
or Att. frer de lirecton n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office		(Street and Number or Rural Route Number, wn, State)
pital o		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and r	place, and due to the	e cause(s) and manner as stated
Little Hospital or Attending Physician: within 24 hours after death to the Funeral Director. After this certifica completely filled in by the funeral director,	edical	(Check only one)    Check only one   Che			
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
10		Nina Paris	D41162		October 9, 2007
10		30. Name and address of person who completed cause of death (Item 23a) (Typ		1m 000=	
	•	Dr. Vinu Ganti M.D. 19529 Doctors D  31. Date filed (Month, Day, Year)  32. Majistrar's Signature		, MD 2087	4
Sta Registr		31. Date filed (Month, Day, Year) OCT 1 0 2007  32. Digistrar's Signature	parti		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07733 State of Maryland / Department of Health and Mental Hygiene Hope Michelle Dixon Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 3, 2007 1831 hrs Medical Examiner 0 MICHEUE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Forestville 5839 Hilmar Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Wash.D.C. 34 Country) 711 2503 Director M 2 VF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State any Yes 2 No Succession of the Medical Examiner must be notified at our matte event, the Medical Examiner must be notified at our contact or the Medical Examiner must be notified at our contact or the Medical Examiner must be notified at our contact of the Medical Examiner must be notified at our contact of the Medical Examiner must be notified at our contact of the Medical Examiner must be notified at our contact of the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner must be not the Medical Examiner MDPages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country' 10e. Street and Number USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 11, Marital Status Armed Forces? 1 Never Married Yes Yes 2 No specify: Yes Give Yea Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) TH . W WASH 340 0 of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition MD. t: If i 2 Cremation 3 Removal from State Burial Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licenses NW. WASHINGTON DC 20011 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death /Medical a Intraoral gunshot wound Immediate Cause (Final disease **k**aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED y the attending physician shed for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o Yes 2 ✔ No 3 Probably 4 Unknown ğ Ō. Completed 24b. Were autopsy findings available Records, 24a. Was an has been prior to completion of cause of autopsy death? performed? ✔ Yes 2 1 🗸 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> Residence 6 V Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 After this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year Oct 3, 2007 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot self Certification: 1818 hrs Yes 2 V No Natural Pending To the Funeral Director: completely filled in by the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) 5839 Hilmar Drive, Forestville, MD determined (Specify) Single Family Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 4, 2007 O.C.M.E. wy astre 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 32. Registrar's Signatur 31. Date filed (Month, Day, Year OCT 0 9 200) State Registrar

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			For State Registrar		State of Ma	ryland / Dep <i>Ce</i>	rtificate of			gienęz U Reg. No.	UI	34290
	Physicia	an	1. Decedent's Name (First,	, Middle, Last	")				2. Date of Dea	_	Year	3. Time of Death
	/Medic		Richard C.		worth				Octobei		007 <sup>ear</sup>	10:55 A M
i	Examin	er	4a. Facility Name (If not in:	_				r Location of Death		4c. County		orge's
			16317 Bawt 5. Social Security Number	try Cou		e (In yrs. last birthday	BOW16	If Under 24 Hrs.	8. Date of Birt	h		
	uneral irector		215-60-9316 Usual Residence of Deced		X 7. Age	54 Yrs.	Months Days	Hours Min.	May 31	,1953	Mar	place (State or Foreign ntry) yland
/land	at			County		10c. City, Town or L	ocation				1	Od. Inside City Limits
Man	a-f sh ified	ţċ	MD Pri	ince G	eorge's	]	Bowie					1 XYes 2 No
th the	or 28 e not	)ire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coul	ntry?
ath wi	23a ust b	Funeral Director	16317 Bawti	ry Cou				715			USA	
er de	items ner m	nue	11. Marital Status	<b>9</b> 5	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub:	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra	ce - Americ ck, White,	
G Z IZ I 3-UU30 filed within 72 hours after death with the Maryland	Department of result and wenter rygener. Innocratic it terms 23a or 28a-f show important: if term 27 is an exted other than "naturali", or item 27 is notified at any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Di		1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No	Specify:		Specia	<sup>ty:</sup> Wh	ite
2 Por	atura ical E			ecedent's Edi		16a. Deci	edent's Usual Occup	pation		16b. Kind of B		
<b>4</b> Fig. 7	an "r Med	Completed	Elementary/Secondary (	y highest grad (0-12)	College (1-4or 5	+)	e kind of work done DO NOT use retired		uig			
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hould	mark	7	James Edward			19h Maii	ing Address (Street	L				Code)
<b>M</b> 2 S	27 is		Mary J. Fern				7 Bawtry (		owie, M		715	0000)
S 1 al	item		20a. Method of Disposition	n	- 44	20b. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Location	- City or T	own, State
Dalumor	in the		1 ☐ Burial 2 ☑ Cren 4 ☐ Donation 5 ☐ C	mation 3 □ Other ( <i>Specify</i>	Removal from State )	1	itan crem		06/2007	Alexa	ndria	, VA.
alit.	porte ny inju		21. Signature of Funeral S	Service Licen	see 0	9 3	22. Name and Addre	ess of Facility B	eall Fu	neral H		
	6 2 2		) CB	uan	fourel		6512 NW C			e, MD.	207	
	/sician	6: 1	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	ease, or comp re. List only o	a. Mu	Itiple.	Myulmg		or respiratory a	rrest,		Approximate Interval Between Onset and Death
	ledical aminer		vecturing in addition		Due to (or as	a consequence of):	/					
ы	8	er	Sequentially list conditions if any, leading to immedia	is, ate	b. Due to (or as	a consequence of):					$\rightarrow$	<del></del>
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Ç e exec	ian ar ırial-tı		resulting in death) Last	- 1	Due to (or as	a consequence of):						
<b>56/50</b> , ificate be executed	physician and s the burial-transit	edical		•	d							
	ding p		IF FEMALE:		23c. If yes, outcome	of pregnancy						
that the death cer	been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	lalit		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of deliv	Day Year
	ned b e deta	by Pt	Part II. Other significant	conditions co	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use cor	ntribute to	the cause of death?
ecords,	en sig ould b								10	Yes 2 No	3☐ Pro	bably 4 □Unknown
Te law	certificate has be ector, page 2 sho	Completed							24a. Was autoj perfo		. Were autoprior to condeath?	opsy findings available ompletion of cause of
	rtifica tor, p	Be C	25. Was case referred to	medical				26. Place of Dea			I LI TES	2 140
S	his ce I direc	To E	examiner? 1 Tes 2 No		Hospital: 1 ☐ Inpatie	ent 2 ER/Outpati	ent 3 DOA Ott	ner: 4 Nursing H	ome 5 Resi	dence 6 □O	ther (Speci	ify)
Ing P	After t		27. Manner of Death 1 Natural 5 □	]Pending	28a. Date of Inju (Month, Da		Wo		28d. Describe	how injury occu	urred	
I or Attending	the f	icati	2☐ Accident 3☐ Suicide 6☐	investigation Could not be		ury - At home, farm, s		]Yes 2□No	28f Location /	Street and Num	aher or Ru	ral Route Number,
٥ آ	Dire Jin by	Certification:	4 Homicide	determined	building, et		arees, ractory, ornoc		City or To		ibei oi rigi	ar noute ivaniber,
Hospita	within 24 routs after beath.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C				of my knowledge, dea						
o the	omple	Mec	29b. Signature and title of	f certifier	b A	4	29c. Licens		0 =	29d. Date sign	ed (Month	, Day, Year)
-			1		TK	1	Do	00425	93	10	11.1	0
1	1				W _			1010		10	141	2007
(	6) He		30. Name and address of		completed cause of d	eath (Item 23a) (Type			I.		201	200 +

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** d3<sup>y</sup> 2007 1:20 P M EDITH L. DAVIS /Medical 4a. Facility Name (If not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner RIVERDALE PRINCE GEORGES CRESCENT CITIES NURSING HOME If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F 88 220-21-9864 Director 12/21/1918 TRINIDAD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show adical Examiner must be notified at MD PRINCE GEORGES ADELPHI YYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2000 ERIE STREET APT. #103 20783 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 1 X ever Married 2 ☐ Married BLACK 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) HOMEMAKER NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 is marked oth Be MARTHA ARNOLD WICLIFE DAVIS မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health ar Important: If Item 27 is any injury or other trauonce. RUTHVEN A. DAVIS/SON 2000 ERIE STREET APT.#103 ALDELPHI, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 10/08/2007 RIVERDALE, MD RIVERDALE CREMATORY 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD., LANDOVER, MD 20785 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) be detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown PERIPHERAL VASCULAR DISEASE Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/04/2007 D64208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

SAADIA HUSAIN 4409 EAST WEST HIGHWAY RIVERDALE, MD 20737 32. Registrar's Signat

			For State Registrar	St	ate of N	/laryland	-	artment o rtificate d			lental H	ygien Reg. N	000	7	34300
8	Physici /Medi		1. Decedent's Name (First, Mid Marion Elizab		pard						2. Date of D Month 10/1	D	ау Yє 07	ear	3. Time of Death 6:50 a M
1	Examir		4a. Facility Name (If not institute MCHS-Potomac			r)		4b. City, Tow		n of Death		1	c. County of E		
S.	Funeral Director		5. Social Security Number 217–32–3529	6. Sex 1 ☐ M		Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Ye	ear If Und	er 24 Hrs. Min.	8. Date of B (Month, £ 11/6	Day, Year	g.	Birthpla Counti	ace (State or Foreigr TV) District Olumbia
	Maryland I-f show fled at	tor	Usual Residence of Decedent	gomery			Town or Lo	cation						10	od. Inside City Limits 1 ☐ Yes 2 🛣 No
	3a or 28a	al Director	10e. Street and Number  8715 Burdette					10f. Zip Coo					itizen of Wha		,
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	12. V	Vas Deceder Armed Forces Yes 25 Yes, Give Year or Dates	s? ¶No		Was Decedent If Yes, specify ( 1 ☐ Yes 2 ☐X	of Hispanic Cuban, Mexi		ecify Yes or N Rican, etc.)		14. Race - A Black, V Specify:	America Vhite, e	ın Indian, tc.
21215-0036	d within 72 hogiene. giene. er than "natu the Medical	Completed by	15. Deceder (Specify only high Elementary/Secondary (0-12)		n <i>npleted)</i> College (1-4o	r 5+)	(Give life. I	dent's Usual Oc kind of work do DO NOT use re emaker	cupation ne during n tired)	ost of work	ing	1	Kind of Busin n Home	ess/Indu	ıstry
Maryland	2 should be filed v and Mental Hygie is marked other t aumatic event, th	To Be (	17. Father's Name ( <i>First, Middl</i> <b>Richard Baxter</b> 19a. Informant's Name/Relation	Thiba			19b. Mailir	ng Address (Str	Mar	ie El	e (First, Middi izabet al Route Num	h Ni	es	ite, Zip (	Code)
Baltimore, Ma	ages 1 and 2 and 2 and 5 and 5 and 5 tri free 27 is 7 or other trace		Marion Mudd/Da  20a. Method of Disposition  1 X Burial 2 □ Cremation	n 3 □Remo		E Cat	ace of Dispo	Burdett sition (Name or natory or other Heaven	place)	ı	Date	20c. I	20817 Location - City	,	
Baltin	permit. Pages Department of Pluportant; if ite any injury or of once.		4 □ Donation 5 □ Other  21. Signature of Funeral Service	Me		Cem M00956	retery The 9:	Name and Ac nibadea 33 Gist	Ave.	uary LL,	Silver	e, E Spr	ver Sp A. ing, M	1D	20910
8/60,	Physician /Medical Examiner be executed bhysician and sthe buriar-transit	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Possi Due to (or a	line. ble In as a consequ	itestin ence of): ial Dis	nal Obs							Approximate Interval Between Onset and Death
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or Vital Records,			OF Was seen referred to made								pei 1□ Yes	topsy rformed? 2 1 N	prio dea	r to com th?	ssy findings available apletion of cause of 2 😾 No
DIVISION OF VIT	or Attending Phy fter death. Director: After this in by the funeral d	25. Was case referred to medical examiner?  1						f 28c.	Other: 4   njury at Work? I □ Yes 2	Nursing Ho	28d. Describe	sidence e how inj	and Number o		Route Number,
_	ie Hospital or A 24 hours after ie Funeral Dire pletely filled in b	edical Ce		al Examiner:		of examinat		h occurred at th vestigation, in r							
7	To the within 2 To the comple	Me	29b. Signature and title of certifier					29c. License number 29d. Date signed ( <i>Month, Day, Year</i> )  D0054566 10/10/2007				Pay, Year)			
÷	Sta Registi		30. Name and address of persons Sunigha Bhogaz 31. Date filed (Month, Day, Yes OCT 1	illi,	MD 14	702 C	herry	Leaf Te	rrace	Sil	ver Sp	ring	, MD	2090	)6

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:50pmM **Physician** 10/05/2007 Veronica E. Erickson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Churchton 1248 Ellicott Ave. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) GA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 3/13/1913 1 □ M 2 🖸 F 94 Director 577-28**-**3717 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Churchton MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20733 1248 Ellicott Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Completed by 3 Novidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Office Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Gay John Daly P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1248 Ellicott Ave. Churchton, MD 20733 Grandson Mike Cissel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery | 10/13/2007 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) the 8 9 Unknown 9 Unknown cate has been signed by to page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2□ No 1∐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, it 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RV2 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 0 2007 Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

Examir

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

						October 3 2007 4:30 A											
er		4a. Facility Name (If not institution, give street and number)							4b. City, Town, or Location of Death  Lanham					4c. County of Death  Prince George's			
		6825 Nashville Road  5. Social Security Number   6. Sex   7. Age (In yrs. last birthde								1 r 24 Hrs.	0 0-44	Diath	Prin				
	467-20-6002	1	02KIM 2□F		88	Yrs.	If Under Months	Days	Hours		8. Date of (Month, June	Day, Ye.		9. Birti Co.	hplace <i>(Sta</i> <i>untry)</i> <b>Te</b> x		
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location																	
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Completed	Elementary/Secondary (0-12	Elementary/Secondary (0-12)   College (1-4or 5+)							uter Systems Analyst Fede						vernm	ent	
BeC	17. Father's Name (First, Middle, Last)								18. Moth	ner's Name	(First, Mid	dle, Maic	en Surnai	me)			
일	Mack Edwards									1	Nell I	ynsl	tey				
	19a. Informant's Name/Relationship (Type. Print)  Deanne Edwards/Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z  6825 Nashville Road, Lanham, Maryland																
	20a. Method of Disposition	15/W	TIE		20h Pia	ce of Dispo			Te K		Lanna				20700 Town, State		
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other			m State	cer	netery, cren	natory or c	ther place	6)		2/2001	- 1			Texas		
	21. Signature of Funeral Service			/		22	. Name ar	nd Addres		lity		473	9 Ba	1time	ore A	zenu	
_ \	1 hichelle	0.	I hand	e M	1014	Ga Ga	sch'	s Fur	neral	l Hom	e, PA	Нуа	ttsv	ille	, MD	207	
	23 Part1. Enter the disease, shock, or heart failure. L	or m	plications tha	at caused the	e death.	Do not ente	er the mod	de of dying	g, such a	s cardiac o	r respirator	y arrest,			Approxir Interval	nate Betweer	
	23. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lip only one cause on each line.  Immediate Cause (Final disease or condition												Onset a				
	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):																
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Registr

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State of Maryland / Department of Health and Mental Hygiene

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29b. Signature and title of certifier  O.C.M.E.  October 16, 2007  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month Day) Year) 2007  33. Registrar's Signature	the d	튄	Part II. Other significant cond	1		resulting in the	underlying o	cause g	iven in Pa	irt I.	23e. D	id toba	cco use cont	ribute to	the cause of de	eath?
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State of Maryland / Department of Health and Mental Hygiene

	Physici /Medio Examin	al	
	Funeral Director		
ere, Maryland 21215-0036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I then 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 2, 2007 8:05pM Ann Ferguson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, 9. Birthplace (State or Foreign Country)
D. C. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 1 M & F 578-40-5101 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Takoma Park Md. 1**X**]Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7600 Maple Avenue #1512 20912 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private School Elementary/Secondary (0-12) College (1-4or 5+) Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Reavis Anne Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ferguson Streeter (Daughter) 2323 St. Clair Drive Temple Hills, Md. 20748

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Department or
Important: If i Physician /Medical Examiner

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Certification: To

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Pages 1

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Physician:

or Attending

Baltimore,

Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3447 14th St., N.W. C. Dacon, CC361 W. H. Bacon Funeral Home, Inc. Washington, DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

20a. Method of Disposition

1 ☐ Burial 2X Cremation 3 ☐ Removal from State

Due to (or as a consequence of): OVASCULAR ACCIDENT CEREBROVASCULAR ACCIDENT PREVIOUS Due to (or as a consequence of)

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Completed by

If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. D) DIABETES MELLITUS, (3) PHEUMOHITIS

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown

20c. Location - City or Town, State

Beltsville, Md.

(6) ATMAL FIBRILLATION DISEASE

CHEMIC GANGGENE-RIGHT FOOT (5) CORONARY ARTER 1242. Was an autopsy (7) ENTERO COLITIS

24593

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes

Year

25. Was case referred to redical examiner? 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

3331-TOLDDOTERRACE

Date

10/05/2007

28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending 2 Accident 3 ☐ Suicide

investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Morammed A. N

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type MOHAM WPD A · MAHAH)

determined

State Registrar

31. Date filed (Month, Day, Yea
OCT 0 9 2007

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 10

2007

32. pgistrar's Signature

		1	State of Maryland / Dep  State of Maryland / Dep  Registrar  Ce	artment of Health and M rtificate of Death	Mental Hygiene 2007 34306
	Physicia	an	1. Decedent's Name (First, Middle, Last) HENRIETTA H. GREEN		2. Date of Death  Month OCT . 6, 2007  3. Time of Death 8:00 P M
)	/Medic Examin	- 1	4a. Facility Name (If not institution, give street and number)  Casey House	4b. City, Town, or Location of Death Rockville	4c. County of Death MONTGOMERY
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birthday, 90 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 24, 1917  9. Birthplace (State or Foreign Country) Maryland
land	It ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
A Mary	aa-f sh	ctor	MD Montgomery	Germantown	1 <b>¼</b> ves 2 □ No
with th	3a or 2	Dire	10e. Street and Number 19519 Crystal Rock Dr. #11	10f. Zip Code 20874	10g. Citizen of What Country? U.S.A.
U Z I Z I 3-0030 filed within 72 hours after death with the Manyland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
	natural"	ted b	3X Widowed 4 □ Divorced       Year or Dates:         15. Decedent's Education (Specify only highest grade completed)       16a. Decedent's Given the completed of the completed of the completed of the completed of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete	edent's Usual Occupation	16b. Kind of Business/Industry
within	ene. than "r h Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired) Housekeeper	Private Home
ביילופיל פוניים	tal Hygi	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)
I VIG	marker marker	2	Ernest S. Hoes  19a. Informant's Name/Relationship (Type. Print)  19b. Mail		Tulia Hall ral Route Number, City or Town, State, Zip Code)
i, INIC	ealth ar n 27 is ner trau		Kenneth Green (Son) 175	46 Black Rock F	Rd, Germantown, MD 20874
nore	set of He			ematory or other place)	Date 20c. Location - City or Town, State Clarksburg, MD
	Departme Importan any injur		21. Signal of Funeral Service Licenses	22. Name and Address of Facility SN	OWDEN FUNERAL HOME, P.A. on St, Rockville, MD 20850
T,	L.		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or head failure. List only one cause on each line.		
	hysician /Medical		Immediate Causa (Final disease or condition resulting in death)  a. Lymphoma  Due to (or as a consequence of):		
Ε	xaminer	_			
5	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
on,	hysician and the burial-transit	ical Exa	resulting in death) Last  Due to (or as a consequence of):		
09/89	incate ig physias the	Medica	d		
	w requires man the beant benimbare been signed by the attending phys should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
ds, F.	requires tracture een signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the  Acute Renal Failure	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
ပ္မ	as been 2 shoul	Completed			24a. Was an autopsy findings available prior to completion of cause of
r	ate h				performed? death? 1 Yes 2 No 1 Yes 2 No
r vital	S 0 0	To Be	25. Was case referred to medical examiner?  1  Yes 2 No		th (Check only one) ome 5□ Residence &XX ther (Specify Hospice
	aling J. After fune		27. Manner of Death  1.	of 28c. Injury at	28d. Describe how injury occurred
Division	deat deat ctor: y the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of injury - At home, farm, so building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	no the Hospital of A within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only) one)  Check only)  2 Medical Examiner: On the basis of examination and/or and manner stated.		
i	within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number D0064615	29d. Date signed (Month, Day, Year) 10/8/07
	6		30, Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)	20850
	C	ate	21 Data filed (Manth Day Year) 22 Diffrietrario Signaturo		Mill Rd, Rockville,MD
	Sta Regist		OCT 10 2007	facili	

Certificate of Death

10:27 A.M

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leg. No.	4	U	U	1	J	4	J	U	
th					3. Tin	ne of	Dea	ath	_

1. Decedent's Name (First, Middle, Last) Physician Month Day Beulah Mae Williams Gibson /Medical October | 4,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 8. Date of Birth (Month, Day, Ye 10/16/45

9. Birthplace (State or Foreign Littleton, N.C.

> 10d. Inside City Limits 1 X Yes 2 ☐ No 10g. Citizen of What Country?

U.S.A.

Black, White, etc. Black Specify:

16b. Kind of Business/Industry

Annuitant Insurance Specialist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 University Dr., Waldorf, Maryland 20602

20c. Location - City or Town, State

22. Name and Address of Facility 4945 Burroughs Ave., N.E, Washington, D.C. 20019

Approximate Interval Between Onset and Death

23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 XNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

( RMOY ANI WALDORF MI 32. Registrar's Sign

Registrar

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of

law requires that the death certificate be executed

Box 68760.

Ö

Δ.

Division or Vital Records,

Hospital or Attending Physician:

1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT. 2007 ROBERT HARRISON HUFF 1:58P M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 8. Date of Birth (Month, Day, DEC 17 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
VA Min. 1935 1 M 2 □ F Months Days Hours 71 223-46-3415 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County GERMANTOWN MONTGOMERY 1 ☐ Yes 2 ▼No MD Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20874 17305 FLAGSTONE DRIVE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 21 Married 2 No 1 ☐ Yes 2 ☑ No WHITE Specify. Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION PAINTER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HAZEL OWENS RAYMOND WASHINGTON HUFF 19a. Informant's Name/Relationship (Type. Print)
BETTY HUFF / SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17305 FLAGSTONE DR., GERMANTOWN, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN CEMETERY 10/13/07 FREDERICK, MD 4 Donation 5 Dother (Specify) 21. Signatur f Funera Service Licensee P. Name and Address of Facility
HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6.5 hrs RESPIRATORY DECOMPENSATION disease or condition resulting in death) Due to (or as a consequence of): 16 hrs ACUTE ABDOMINAL PAIN Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 yrs Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 □ Yes 2 □ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NON-HODGEKINS LYMPHOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of OCT 10, 2007 D31840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #214

DHMH 17 Rev 1/2001

State

Registrar

WAYNE MEYER,

OCT 1 2 2007

31. Date filed (Month, Day, Year)

ROCKVILLE,

MD

20850

MD 9715 MEDICAL CENTER DR.,

pegistrar's Signature

32.

State of Maryland / Department of Health and Mental Hygiene 34309 Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Quentin Louis Hittle, Sr. 11:15 PM 2007 October 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) June 2, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2∏ F 218-12-6216 88 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Davidsonville 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21035 1755 Governor Bridge Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Ş Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Farming Agriculture 8 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h Alousia (unknown) Joseph Hittle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1755 Governor Bridge Road Davidsonville, MD 21035 Doris L. Hittle/wife of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Important: If it any Injury or c once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 10/10/2007 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home ure of Fureral Service Lice ee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Atrial Fibrillation burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the at d be detached fo 5 Other (specify) 1 □ Yes 2 □ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Anemia, GI Bleed, Hyperlipidemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s performed? Yes 2█No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2XX €R/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) XX Natural 5 ☐ Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062534 October 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, Rita Dhawan, MD 144 Washington Road Edgewater, MD 21037 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene

			State Registrar	•	ertificate of l		Re	eg. No. 2	2007	34310	
	Physicia	ın	Decedent's Name (First, Middle, Last)  CHIDDEN  A  H  CHIDEN  A  H  CHIDDEN  A  H  CHIDEN  A  H  CHIDDEN  A  CHIDDEN  A  CHID  A  CHID  A  CHID  A  CHID  A  CHID  A  CHID  CHID  A  CHID  CHI	A T T			2. Date of Deat Month	Day	Year	3. Time of Death	
	/Medic Examin		SHIRLEY A. H.  4a. Facility Name (If not institution, give street and number)	ALL	4b. City, Town, or	4b. City, Town, or Location of Death			18, 2007 6:05 A M		
	LXamiii	GI	SOUTHERN MARYLAND HOSPITA	$_{ m AL}$	C	LINTON		PRI	NCE GEO	ORGES	
8	Funeral Director			e (In yrs. last birthda 79 Yrs	ay) If Under 1 Year		8. Date of Birth (Month, Day, NOV • 10	Year)	9. Birthp Cour	place (State or Foreign htry) SH. D.C.	
	/land ow at		10a. State 10b. County	10c. City, Town or	r Location				1	10d. Inside City Limits	
	a-f sh	ctor	D.C. NONE		WASHINGTO	N				1 ☐ Yes 2 ☐ No	
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizer	n of What Cour	ntry?	
	s 23a		5114 HANNA PL. S.E.	Sugar in 11 C	200		poifu Voc or No	14	U.S.		
_	ter de Item	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>		Rican, etc.)	14	Black, White,		
20	hours after tural", or Ite	۵	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		S	pecify: BL.	ACK	
15-0036	be filed within 72 hours after death with the Marylar tall Hygiene. And Hygiene. And Cather than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	I (G	ecedent's Usual Occup	durina most of work	ing	16b. Kind	of Business/In	dustry	
7	filed within 72 Hygiene. ther than "nat int, the Medica	ldw	Elementary/Secondary (0-12) College (1-4or 5	+)	fe. DO NOT use retired PRACTICAL				NURSIN	G	
N D	filed Hygie		17. Father's Name (First, Middle, Last)		INK.	18. Mother's Name	e (First, Middle, i	Maiden Su		UNK.	
<u>a</u>		To Be			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
Maryland	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)	19b. M	lailing Address (Street	and Number or Rur	al Route Numbe	r, City or T	own, State, Zij	Code)	
_	and 2 ealth m 27 i		JOAN E. GREEN/NIECE		12 SHOLTON		PER MARL				
0	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	isposition (Name of crematory or other place	1			tion - City or T		
Baltimore,	artmer artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	HARMON	Y MEMORIAL 22. Name and Addre		the same and the same at the same at the		OOVER,		
g	Dep Impo		Valle Chambrus	2 M0009	22. Name and Addre CHAMBERS 5801 CLEV	ELAND AVE	E., RIVE	RDALI	CORLUM, E, MD.	P.A. 20737	
	Ar And		23a. Part1. Enter the disease, or complications that come shock, or heart failure. List only one cause on the Immediate Cause (Final	the death. Do not ne.	enter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a consequence Th	10.2	1.2 X					
	Examiner		(IV)	ada)	1104	14/20/18	Z.				
	P ≓	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):							
	icate be executed physician and s the burial-transit	Examiner	triat initiated events C	a consequence of):							
90	be exician		3	a consequence en	•						
68760	ificate be executed g physician and as the burial-transit	edical	d								
.O. Box	attendin for use	Physician/M	1 Ves 2 Months? 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у	_	23	d. Date of deliv	very Day Year	
P.O.	at the by the tache	hys	9 ☐ Unknown				T				
ŝ	w requires that the do been signed by the should be detached		Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death out not resulting in the underlying cause given in Part I.								
000	requi	Completed by		(							
Records,	ne law has b ge 2 s	mpl				<del></del>		sy med?_	prior to co death?	opsy findings available ompletion of cause of	
Vital	an: TI tificate or, pa		25. Was case referred to medical			26. Place of Dea		2 No	1 □ Yes	2∐ No	
	yslcia is cer direct	To Be	examiner?  1 Yes 2 No Hospital: 1 Impati	ent 2 ☐ ER/Outp	atient 3 DOA Oth	or:	ome 5 Resid		☐Other (Spec	ify)	
0 1	ng Ph fter th neral		27. Manner Death 28a. Date of Inj. 1 → Atural 5 □ Pending (Month, De		ury Wo		28d. Describe h	ow injury	occurred		
Sio	tendl leath. tor: A the fu	catio	2 ☐ Accident investigation			Yes 2 □ No	006 Lengtion /6	'ève et o mal	Number or Bu	ral Pauta Number	
Division or	after d Direc	Certification:	dotorminad 200. Place of III	tc. (Specify)	n, street, factory, office		City or Tou		Number or nu	ral Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/	death occurred at the to	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To th within To th compl	Me	29b- Signature and title of certifier		29c. Licens	oo 463			signed (Month		
			30. Name and address of person the completed glues of	death (Item 23a) T	ype, Print) 1328500	they Ave	EW	20	201	32	
	Sta			rar's Signature	9 -0						
	Regist	rar	CCT 2 5 2007	21 D. p.	merce)						

hysicia	ın	I - State State Registrar Amend 19a, perFH, 6872 10/29/07 TT Certificate of Death  1. Decedent's Name (First, Middle, Last)  Thomas Glen Holden  State of Maryland / Bepartment of Health and Mental Tyglene 20  2. Date of Death Month Day Sept. 26, 200	Year 10:20a <sup>M</sup>
/Medic xamin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County or	
		, , , , , , , , , , , , , , , , , , , ,	gomery
neral ector		5. Social Security Number 230–38–9753 Tyles and the security Number 230–38–9753 Tyles are security Number 230–38–38–38 Tyles are security Number 24 Hrs. Nonth, Days Hours Number 24 Hrs. Nonth, Days Hours Number 24 Hrs. Nonth, Days Hours Number 24 Hrs. Nonth, Days Hours Number 24 Hrs. Nonth, Days Year)  Usual Residence of Decedent	9. Birthplace (State or Foreign Country) North Carolina
a-r snow		10a. State 10b. County 10c. City, Town or Location Hyattsville	10d. Inside City Limits  X□Yes 2□No
zsa or zsa	Funeral Director	10e. Street and Number       10f. Zip Code       10g. Citizen of W         5410 76th Avenue       20784       U. S. A	
Important: If Item 27 is marked other than "natural", or items 23a of 26a-1 show any Injury or other traumatic event, the Medical Eximiner must be notified at once.	þ	11. Marital Status  Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black	- American Indian, c, White, etc. Black
Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	
ed otner tr event, the	Be	12th   Glocel  17. Father's Name (First, Middle, Last) unknown   18. Mother's Name (First, Middle, Maiden Surname Mozelle Williams	
27 is mark er traumatic	으	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Spianna Maria Seay Holden (Wife)  5410 76th Avenue Hyattsville,	·
ant: If Item ury or othe		1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  **Commetery, circulatory or other place)*  Mt. Olivet Cemetery  10/05/2007 Washing	city or Town, State
importa any Inju once.		Wanda C. Dacon CC 36/ W. H. Bacon Funeral Home, Inc. Wa	47 14th St.,N shington,DC 20
ician dical niner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure  Due to (or as a consequence of):	Approximate Interval Between Onset and Death I nour
physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pneumonia  Due to (or as a consequence of):  Stroke  C.  Due to (or as a consequence of):	1 month
s been signed by the attending phy should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	e of delivery nth Day Year
n signed b			ribute to the cause of death? 3 ☐ Probably 4 🍱 Unknow
After this certificate has bee funeral director, page 2 shores	Completed by	autopsy performed?	Were autopsy findings availab prior to completion of cause of death? ☑Yes 2☐No
ertifica ector, 1	BeC	25. Was case referred to medical 26. Place of Death (Check only one)	
this c al dire	은	1   Yes 2 X No	
ctor:	Certification:	1 Natural   5   Pending   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Bell Reserved   2   Accident   5   Pending   (Month, Day Year)   2   Suicide   2   Suicide   4   Homicide   2   Suicide   4   Homicide   2   Suicide   2   Suicide   2   Suicide   2   Suicide   2   Suicide   2   Suicide   3   Suicide   4   Homicide   2   Suicide   5   Suicide	
To the Funeral Dire completely filled in b	edical Ce	29a. Certifier (Check only one)  11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and ma cause(s) and	anner as stated. and due to the cause(s)
	Me	29b. Signature and title of certifier  29c. License number  MD 52120  29d. Date signer  Sept. 2	d (Month, Day, Year) 6, 2007
To th comp		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	

DHMH 17 Rev 1/2001

3. Time of Death

10:30P M

Certificate of Death

OCTOBER 4 2007

2. Date of Death

Physic	ian
/Medi	cal
Exami	ner

JESTINA

4a. Facility Name (If not institution, give street and number) FAIRLAND NURSE & REHAB CENTER 6. Sex

AYO

1 ☐ M 2 🂢 F

4b. City, Town, or Location of Death SILVER SPRING

4c. County of Death MONTGOMERY

Year

**Funeral** Dírector

r than "natural", or Items 23a or 28a-f show the Medical Exeminar count be coulded at

Funeral

δ

Be Completed

the Maryland

within 72 hours after

i and 2 should be filed with Health and Mental Hygiene. em 27 le marked other than

permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 1e
eny injury or other trau

**Physician** 

The law requires that the death certificate be executed

or Attending

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

use as the burial-transit

attending physician and

signed by

been

has

Director: /

within 24 hours a

Illed in by

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a State MD Director

10b, County MONTGOMERY 10c. City, Town or Location

7. Age (In yrs. last birthday)

79

10f. Zip Code

20910

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | MAX 27 1928

9. Birthplace (State or Foreign SIERRA LEONE

10d. Inside City Limits

Yes 2 No

10e. Street and Number

5. Social Security Number

216-29-3693

SILVER SPRING

10g. Citizen of What Country? U.S.A.

2101 FAIRLAND ROAD

1 Never Married 2 Married

3 Widowed 4 □ Divorced

1. Decedent's Name (First, Middle, Last)

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes Give

HEBRON

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify:

14. Race - American Indian. Black, White, etc.

BLACK

15. Decedent's Education (Specify only highest grade completed)

16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12th

College (1-4or 5+)

ADMINISTRATOR

1 □ Yes 2X No

GOVERNMENT

17. Father's Name (First, Middle, Last)

SAMUEL MACFOY

18. Mother's Name (First, Middle, Maiden Sumame) MILDRED

MACFOY

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

186 CROMWELL LANE CONVENTRY, ENGLAND CV48AP Date 20c. Location - City or Town, State

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

ELIZABETH CYNTHIA MCCOLL/DAUGHTER

RIVERDALE CREMATORY

10-8-2007

RIVERDALE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Metastatic	Pancreatic	Cancer
Due to for as a consequi	ence of):	

<u>Anemia Bipol Disorder</u> Due to (or as a consequence of):

HTN, DEMENTIA Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy

23d. Date of delivery Day Month

Year

Approximate Interval Between Onset and Death

4 Pregnant at time of death 9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 © Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2 No

29d. Date signed (Month, Day, Year)

OCTOBER 5 2007

1 ☐ Yes 2 X No 27. Manner of Death 1 X Natural

2 Accident

3 Suicide

4 Homicide

25. Was case referred to medical

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3□ DOA 28b. Time of Injury

28c. injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check-off

🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0064578

29b. Signatup and title of certifier

hely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2ns Avenue # 404B Silver Spring Maryland 20910 Ravi Passi M.D. 8609

31. Date filed (Month, Day, Year) OCT 0 9 2007 State Registrar

32. Registrar's Signature. B.

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34313 State of Maryland / Department of Health and Mental Hygien 2007 For State Registrar Amend#5.15.16bPerEFHPGC10-9-07cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** IMAGHR AHME 2007 0520 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery

9. Bunplece (State or Poreign
Country) HOSPITAL GROVE KCAHZ brouthersburg If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, **Funeral** Days 1 M 2 □ F MOYOCCO Director 01-01-1940 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours after deeth with the Marylan lith and Mentel Hygiene. 27 is marked other then "naturel", or Items 23a or 28s-f show treumatic event, the Medical Examinat must be notified at Gaithersbur Monta 1 Yes 2 □ No MD **Funeral Director** omeri 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20874 Court Murocco stone 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private College (1-4or 5+) 5± Elementary/Secondary (0-12) Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be IMAGHRI HBDESALAM Pages 1 end 2 should P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2. Department of Heelth a Important: If Item 27 is eny injury or other treugonce. OUAFAF Key stone MD.20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Lation - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Morocco Morocco 10-11-07 4 □ Donation 5 □ Other (Specify) Aden Muslim Funerar 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ERSY St. Woodbridge VA.22191 124a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Manai Failure /Medical Due to (or as a consequence of): Examiner 2 129 Sequentially list conditions, Examiner If any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funerel Director: completely filled in by the investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Carifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. Licease number 30. Harrie and address of person who complet of cause of death (Item 23a) (Type, Print) 15225 Shady Grove Suite 209 Rockville Md >aua 31. Date filed (Month, Day, Year) 32. Registrar's State OCT 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- Per Phy G872 10/29/07 Ih Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month OCT. **Physician** MARY JANE ELIZABETH JACKSON 6, 1835 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 66 Mar.6,1941 Maryland 215-46-0948 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits Director MD 1 □ Xes 2 □ No Montgomery Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22916 Mt. Ephraim Road 20842 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black Specify: Ş Q 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Children's Center Elementary/Secondary (0-12) College (1-4or 5+) llth Child Care for Discovery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Carter Nellie Chase ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis P. Jackson 22916 Mt Ephraim Rd, Dickerson, MD 20842 (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 4 Domation 5 Other (Speelly) Fairview Cemetery 10/11/07 Frederick, MD Si of ture of Funeral Service s 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial ows Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death

**Physician** /Medical Examiner The law requires that the death certificate be executed burial-transit

and

physician

the

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the

for use

**Funeral** 

Director

r 28a-f show notified at show

a or ns 23a /

r than "natural", or items the Medical Examiner my

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event sone.

traumatic event,

Maryland 21215-0036

altimore,

Box 68760.

P.O.

Division or Vital Records,

Hospital or Attending Physician:

after death

24 hours a

within 24

P 2

Examiner Physician/Medical signed b Completed by Certification: To

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🗷 Natural

2 Accident

3☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

00064068

29c. License number

29d. Date signed (Month, Day, Year) October 6th 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 medical Conter Prive Rocking MD MO 31. Date filed (Month, Day, Year)

State Registrar

5 Pending

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n Baltimore, Maryland 21215-0036

> **Physician** /Medical

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran

P.O. Box 68760, Division or Vital Records, certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State of Maryland / Department of Health and Mental Hygiene State RegistrarAMEND#23a(c)perMF10/10/07, BMWANGGEate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3, 2007 04:11 A M October Marie Elizabeth Joslin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🗓 F 11/01/1919 Washington 532-12-6048 87 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1X Yes 2 No Bethesda Maryland | Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7420 Westlake Terrace #1109 20817 United States Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗓 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 2 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delia Hendrickson Henry Ahlvers မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Eugene Joslin/ Husband 7420 Westlake Terrace #1109 Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemet. 11/05/2007 Arlington, Virginia 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signatury of Euneral Service Licepsee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cardiac Arrest resulting in death) Due to (or as a consequence of): 2 Days Respiratory Failure Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sea consequence of: Aspiration pneumonia Aspiration Completed by Physician/Medical Examine Due to (or as a consequence of): Urinary Tract Infection IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Sepsis, Hypotension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1☐ Yes 1 ☐ Yes Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DØ6578 October 3, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamid Majdizadeh MD 9901 Medical Center Drive Rockville, MD 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) **OCT 1** 0 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician George Henry Jones, Jr. 0ctober /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care of Silver Spring Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 □ F Director 236-28-5990 80 October 15,1926 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location Show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Director Maryland Montgomery Burtonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14103 Armilla Court 20866 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ WWII 3 ☐ Widowed 4 ☒ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Lawyer 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any Injury or other traumatic eveni Be Anna May Wells George Irenes Jones 19a. Informant's Name/Relationship (Type. Print) Keith Jones - Son 3737 Center Way, Fairfax, Virginia 22033 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2007 Mt. Hope Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Systemic Sepsis /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accidents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of ) Examiner the death certificate be executed attending physician and for use as the burial-transit Metastatic Prostatic Carcinoma Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Martinsburg, West Virginia Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death Months Years Years 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) October 9, 2007 D17874 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 38th Avenue, Cottage City, Maryland 20722 ORIGINAL

10:20 p<sub>M</sub>

2007

Montgomery

Birthplace (State or Foreign Country)

10d. Inside City Limits

Black.

1 ☐Yes 2K No

West Virginia

State Registrar

S.M. Nayar, M.D.,

31. Date filed (Month, Day, Year)

3717

0 2007 gistrar's Signature

	4	For State	State of	f Maryland		rtment o			lental Hy	giene	200	7	34317
		State Registrar  1. Decedent's Name (First, Middle,	(ast)		007	imodio	or Boat		2. Date of De	eath		3	. Time of Death
Physici		Matilde		e Joya					Octobe	er 04	, 2007	1	.2:12 p <sup>M</sup>
/Medic Examir		4a. Facility Name (If not institution,				4b. City, Tov	vn, or Location	on of Death			County of Dea	_	
Examir	ier	Southern Mary	_			C1:	inton			Pr	ince Ge	eorg	es
Funeral			6. Sex	7. Age (In yrs. la		If Under 1 Y		der 24 Hrs.	8. Date of Bi	ay, Year)	C	ountry)	
Director		none	1 <b>№</b> M 2□ F	72	Yrs.			I	March 1	4, 1	935 E1	Sa1	vador
pul *		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d.	Inside City Limits
faryla shor	ō		0	For	t Ma	shingto	222						1X1Yes 2 No
the N 28a-i	rect	MD Prince  10e. Street and Number	George's	FUL	L wa	10f. Zip Co				10g. Citi	izen of What C	ountry	?
3a or	Funeral Director	1001 Stag Way				2074	4			E1 S	Salvado	r	
death	ner	11. Marital Status	12. Was Dece	edent Ever in U.S	3. 13.	Was Deceden	t of Hispanic Cuban, Mex	Origin? (Spa	ecify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Wh		
after or ite		1 Never Married 2 Marrie	ed 1 ☐ Yes If Yes. Gi	2∭X No ve	i i	1X Yes 2□			adoran		Specify: Wh	nite	
d <b>Z   Z   5-UU30</b> filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 23a-f show ont, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	16a Dece	dent's Usual C		Salv	adoran		ind of Busines	s/Indus	trv
"nati	ete	15. Decedent' (Specify only highes	t grade completed)		(Give	kind of work of DO NOT use r	done during r etired)	most of work	ing	100111			.,
within iene.	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		mer				Se1	Lf-Empl	oye	d
Hygied other	Be C	17. Father's Name (First, Middle, I	ast)				18. M	other's Name	e (First, Middl	le, Maider	Surname)		
land lid be file Aental H rked oth tic even	TO B	Policarpio And	rade					ominga					
Mary nd 2 shol tth and N 27 is ma trauma		19a. Informant's Name/Relationsh									or Town, State,		
and and m 27 m 27 her tr		Deisy Marina A	lvarez (d	laughter	) 1001	Stag	Way Fo	ort Wa	shingt Date	on Ma	ary Land	2 e Towr	0 / 4 4 . State
ges 1 tofficen or oth		20a. Method of Disposition  1X Burial 2 □ Cremation	3 □Removal from		emetery, cre	matory or othe	er place)		5/2007	Sa	n Migue	<b>2</b> 1	,, 3.4.1
<b>SAILLIMOF</b> Dermit. Pages Department of mportant: If it any injury or once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		Fam		emetery		acility ** T	I Desc	E1_	Salvad		e, Inc.
<b>BAITIMOTE,</b> INITYIANG ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Furieral Service (	7. Bann	u 10 21							n DC 20		
		23a. Part1. Enter the disease, or	complications that	caused the death									pproximate iterval Between
Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	14	1/	4 . 2						onset and Death
/Medical		disease or condition resulting in death)	a	(or as a consequ	ience of):	Du.	196						
Examiner		Comment the link and distance	h	1/2/1	201	BNS	CON					62	nknows
₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	ience of):								
ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	ience of):							+	
. BOX 68/60, death certificate be executed e aftending physician and d for use as the burial-transit	ical E		l .	(0) 40 4 00110040									
68/ ifficate g phys			d										
<b>BOX</b> (eath certification of the aftending for use a	sician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	tcome pf pregna	ncy						23d. Date of		
death death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□Fetal gnant at time of de		□Ectopic preg □ Other <i>(spec</i>				-	Month	D	ay Year
P.O.	Phys	9 Unknown				6.15	l l- F	3-41	220 Di	d tobacco	uea contribute	to the	cause of death?
S, Festha	by F	Part II. Other significant condition	ons contributing to	death but not resu	ilting in the i	inderlying cau	ise given in F	art I.		o tobacco □Yes 2			oly 4 Hinknown
Cords, P.O. Box 68 w requires that the death certifica been signed by the aftending ph should be detached for use as it	ted	HNEN LO											
I <b>Records, P.O</b> The law requires that the ste has been signed by the bage 2 should be detached.	Completed						-		24a. W	as an itopsy erformed?	death	1?	y findings available pletion of cause of
							20.	Diagonal Page	1□ Yes		6 1□Y	es 2	No
Vital Sician: Certifica rector, p	Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2□	EB/Outpatie	ent 3 DOA	Othor		ith (Check onl		6 □Other (S	Specify)	
Vision or Vita Attending Physician: r death. ector: After this certifici	1: 70	27. Manner of Death	28a. Date	e of Injury	28b. Time		c. Injury at Work?				ury occurred		
ion on anding if the r: After e funer	atior	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	9 '	onth, Day Year)	Injury	М	1 ☐ Yes	2 No					
Division or lor Attending Physafter death. Director: After this in by the funeral d	Certification:	3 Suicide 6 Could determ	inod Zoe, Flat	ce of injury - At ho ding, etc. (Specif	ome, farm, s	treet, factory,	office		28f. Location City or	n <i>(Str</i> eet a Town, Sta	and Number or te)	Rural	Route Number,
Div Ital or A Its after Ital Direction by	Cer												
Hospita 24 hours Funeral etely filled	ical	(Check only 2 Medical	e Physician: To the Examiner: On the	basis of examina	wledge, dea ition and/or i	ith occurred a investigation, i	t the time, da in my opinior	ate and place n, death occi	e, and due to t urred at the tin	ne cause ne, date a	nd place, and	due to	the cause(s)
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in I	Medical	one)  29b. Signature and tille of certifie		inner stated.	1	29c.	License num	nber		29d. D	ate signed (M	onth, E	ay, Year)
F B F 8		1 Bonal	Ma	lec	21	E	06	15	(/	00	to Be	7.	5,07
1 12		30. Name and address of person	in completed car	use of death (Iten	n 23a) (Type	e, Print)		01	-		3	-/-	
- (3)		9801 Leon	Li Aue	SE3-	311	X/100	4 5 P	KING	MD	200	102		
	tate	31. Date filed (Month, Day, Year)		Registrar's Signa				7					
Regis	trar	OCT 0 9 2007	Darlin	10. 100	West of the second								

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mber 23 200 **Physician** CHESTER JENKINS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's DOCTOR'S COMMUNITY HOSPITAL Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 3 M 2 □ F Yrs 03-27-1919 88 Director 230-12-2265 Unk. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Directo Lanham Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20706 2800 Good Luck Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unk. Unk. Unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk. Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6420 Allentown Rd. Camp Springs, MD 20748 Rosemary Mason/guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10-06-2007 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANTENIOSCIENOTIC CARDIOVASCULA DISEASE **Physician** 1-enns /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe prior to completion death? 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a the Hospital 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 25,2007

State Registrar

altimore, Maryland 21215-0

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, OCT 0 9 200)

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Queensbury 12d Hyattsu, The Mis 20781

State of Maryland / Department of Health and Mental Hygiene 2007

			1 - State Registrar	•	Cert	ificate of L	Death		Reg. I	2001	34315											
F	Physic	an	Decedent's Name (First, Middle, Last)		_			2. Date of D Month		Day Year	3. Time of Death											
	/Medi	cal	Mary F Jones			4. O't. T	Landing of Doort		10	5 2007	8,20 PM											
	Examir	ner	4a. Facility Name (If not institution, give street and r <b>Crofton Convalescent</b>	number)		Crofton	Location of Death			Anne Aru												
	Funeral Director		5. Social Security Number  579–22–9073  Usual Residence of Decedent  6. Sex  1 □ M 2 ▼ F	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 12/5/1	irth Pay, Yea .924	9. Bird St.	hplace (State or Foreign Louis, MO											
21215-0036	Maryland I-f show fled at	tor	10a. State 10b. County  MD Anne Arundel	10c. City, To		ation					10d. Inside City Limits 1   Yes 2  No											
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 2131 Davidsonville Rd			10f. Zip Code	21114		10g. (	Citizen of What Co	untry?											
	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	Armed	s 2. <mark>A¥</mark> No Give		as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:												
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade complete	16	a. Decede (Give ki	nt's Usual Occupa nd of work done o	ation furing most of work )	king	16b.	Kind of Business/	Industry											
121	within lene. than the Me	duic	Elementary/Secondary (0-12) College	(1-4or 5+)	_	e Manage:			H	ealth Car	re											
Maryland 2	s 1 and 2 should be of Health and Mental Item 27 is marked of other traumatic ever	To Be Co	17. Father's Name (First, Middle, Last)  Matthew Clark				18. Mother's Nam	, ,	e, <i>Maid</i>	en Surname)												
, Mary			19a. Informant's Name/Relationship (Type. Print) Betty 0 Leary/daughter	8	3740 (	Green Fi	eld Ct.,	odento	ber, Cit n, l	y or Town, State, 2 MD 21113	Zip Code)											
Baltimore,					20a. Method of Disposition  1  Bunial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State Fort I	of Dispositery, crema Linco	tion <i>(Nam</i> e of atory or other plac <b>In Cemet</b>	e) ry 10/8	Date <b>/2007</b>		Location - City or ntwood. I										
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	lle	1					Funeral												
	Physician /Medical Examiner	ner	Sequentially list conditions b. N	t caused the death. Do n each line.  Company  Of (or as a consequence  Of (or as a consequence)  Of (or as a consequence)	tia e of):		g, such as cardiac		arrest,		Approximate Interval Between Onset and Death  Jecus  months											
κ 68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Physician/Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	resulting in death) Last C. Due 1	o (or as a consequence	e of):						
.O. Box	at the death ce by the attendi tached for use													ysician/	ysician/	_	_	_	_	23b. Was decedent pregnant in the past 12 months?	outcome pf pregnancy e birth 2 □ Fetai dea gnant at time of death known	
Δ.	w requires that been signed by should be deta			Part II. Other significant conditions contributing to	death but not resulting	in the und	erlying cause give	en in Part I.		tobacc Yes	.v	the cause of death?										
or Vital Records,	The law ate has b page 2 sl			Complete	Complete	Complete						24a. Was auto perl 1∐ Yes	s an opsy formed: 2	prior to death?	utopsy findings available completion of cause of 2 ☐ No							
Z:	Physician: The this certificate all director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/C	Outnatient	3 DOA Othe	26. Place of Deat			6 □Other (Spe												
ion or	Ing After	<b>-</b>	27. Manner of Death 28a. Dal		. Time of Injury	28c. Injury Work		28d. Describe			city)											
Division	Dig Ste	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of injury - At home, ilding, etc. (Specify)	farm, stree	t, factory, office		28f. Location City or To	(Street own, St	and Number or Ru ate)	ural Route Number,											
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the American Examiner: On the and many many many many many many many many	he best of my knowledge basis of examination a anner stated.	ge, death o and/or inve	occurred at the tim stigation, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time	e cause e, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)											
	To the I	Z	29b. Signature and title of certifier  Ra Kelsh Cuo	NG M	D	D2	0 108	3		Date signed (Monto $0/6/C$												
R	(2)		30. Name and address of person who completed ca	MD143	300 (	int) SALLA	NTFOX	LN#	22	2, Bow 11	5,MD20715											
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 0 9 2007	Registrar's Signature	de																	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 34320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month /Medical Gregory Jones 10/4/2007 6:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2575 Oak Glen Way Forestville Prince George's 6. Sex 11 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 579-72-7175 50 6/15/1957 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 1 ∰Yes 2 □ No Director Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2575 Oak Glen Way 20747 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) /, Electrician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Jones Ada Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen McConnell-Jones/Wife 2575 Oak Glen Way, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/13/2007 Brentwood, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 X Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier will mo 0 1 2 2 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16-2 B. Wilks 10200 011 Cc Jums ic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

07-07821 Der

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

metrius Kosh		1-For State Of Maryland / Department of Fleath	Cirio in the circumstance	Reg. I	No.	
Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da October 7, 20	ay Year	3. Time of Death 0357 hrs
‴ંવ્l Exami	ner	DEMETRIUS DONTAE KOSH  4a. Facility Name (if not institution, give street and number)  4b. City, Tov	wn, or Location of Deat		4c. County of Dea	th
		Prince Georges Hospital Center Chever			Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24Hr Days Hours Mil	s. 8. Date of Birth(I	MM/DD/YYYY) 9. B	countrWash. DC
Director		579-04-9154 <sub>1</sub> X <sub>M 2</sub> <sub>F</sub> 27 <sub>Yrs.</sub> Months	Bays	Sept.2	5,198h	countryy a STI. DC
,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d 10w any C.		MD Pr. Geo New Carr	collton			1 XYes 2 No
arylan 8a-f st at onc	Director	10e. Street and Number 10f. Zip C	Code	10g.	Citizen of What Co	ountry?
the M sa or 2 otified	<u>p</u>		20874	Sanifa Van as No	U.S.	A . erican Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Never Married 2 Married 2 Married 2 Married Armed Forces?	t of Hispanic Origin? ( Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
er dea	Fu	1 3 Wildowed 4 Divorced In 1-1				lack
ours afl otoral	d b	for Dates:	occupation (Give kind o	of work done 1 etired)	6b. Kind of Busines	ss/Industry
6 172 ho an "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Techn	ician		Plumbi	ng Co
OO3 within giene. her th	L O	12th 17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		
21215-0036 21215-0036 Judd be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be		Aud	rey Harr	ris	ate Zin Code)
21 hould I nd Men is man	2	19a. Informant's Name/Relationship (Type, Print )	Street and Number of	#304. W	Jashingt	ate, Zip Code) 20009 con DC
, MD and 2 sho ealth and em 27 is traumati	1111	20b. Place of Disposition (Nam	e of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I file m 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trannantie event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State Glenwood Cen	n 10	/16/07	Washing	gton, DC
Iltim nit. Pa artmer sortani		4 Monation 5 Other Specify 22. Name and	Address of Facility S	NOWDEN E	TUNERAL	HOME, P.A.
Dep Der		23a. Part I. Eny r the diserse, or complications that caused the death. Do not enter the mode of	. Washing	ton St, I	ROCKV111 st, shock, or heart	e, MD 20850 Approximate Interval
Physiciar Medica		failure. Int only one cause on each line.	or dying, such as cardia	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Between Onset and Death
_xamine		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	iner	if any, leading to Immediate  cause. Enter Underlying Cause  c.				
h = =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, ate be executed hysician and hurial - transit						
60, ate be e	Modi	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe			23d. Date of del	
Box 68760, a death certificate be the attending physic	in cas un	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe		egnancy	Month	Day Year
Box le death of the atten	1010	1 Yes 2 No 9 Unknown				te to the cause of death?
P.O. Es that the igned by the			g cause given in Part I.			Probably 4 Unknown
S, P.C uires that n signed 1	o ag p	Completed by			an 24b. We	re autopsy findings available
cords, law requir	nous z	<u></u>		autop perfor	med? dea	
tal Rec sian: The L certificate h	bage		26.Place of Death (Ch	1 Yes	2 No	Yes 2 No
ital iician: s certii	lector d	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3	10th am	ursing Home 5		Other:
of Vital Records, ing Physician: The law requir Physician: The law requir	লু   ⊦	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Panding Oct 7, 2007  28b. Time of Injury Oct 7, 2007  0208 hrs	28c. Injury at Work?	Subject was	now injury occurred s shot	
ion tendin eath.	the fu	1 Natural 5 Pending Oct 7, 2007. 1887 0208 hrs	1 Yes 2 V No		Street and Number	or Rural Route Number, City
Division tal or Attendir as after death.	d in by	28e. Place of Injury - At home, farm, street, factor	y, office building, etc.	or Town S		
			ne time, date and place	and due to the caus	se(s) and manner a	s stated.
the H thin 24 the Fe	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.	ny opinion, death occur	red at the time, date	and place, and due	
To To	9		9c. License number		October 7, 2	(Month, Day, Year)
		my his mos	O.C.M.E.		October 7, 2	
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Bal	timore, MD 21201	1		
	Sta	Ling Et, MD				
	ەرە istr	ate 31. Date filed (10 mm Pay, Team 2007)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 8, 2007 **Physician** Annabelle Katz Noon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 5610 Wisconsin Avenue, # 603 8. Date of Birth (Month, Day, Year) Nov. 17, 1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Illinois 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□F 80 Director 579-24-1080 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-diral Examiner must be notified at Yes 2□No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 5610 Wisconsin Avenue, # 603 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White \$ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 4 Years Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Norinsky Samuel Madorsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health at Important: If item 27 is any Injury or other trauguce. 9212 Fall River Lane, Potomac, Maryland Linda K. Hartman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ARemoval from State Falls Church, Virginia King David Mem Gdns 10/10/2007 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service License 20852 23a. Part1. Enter the disease, or complications that caused de death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a snsequence of): mos COPT 1730 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown as been signal Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an pade performe 1□ Yes 2XLNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 25 No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

**Physician** /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

certificate

Baltimore, Maryland 21215-0036

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tit

29c. License number 20014111 29d. Date signed (Month, Day, Year) October 9, 2007

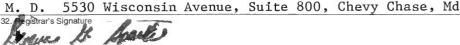
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20815

State Registrar

Medical

Jerome S. Putnam, 31. Date filed (Month, Day, Year) OCT 1 0 2007



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	Certificate o	of Death		Reg.	No.	
Physicia	n/	Decedent's Name (First, Middle,Last)	.1			2. Date of Death Month	Day Year	3. Time of Death 0756 hrs
ledical Examir		John Casimar Kro		4b. City, Town, or	Location of Death	October 3, 2	4c. County of Deal	
		Doctor's Community Hospital	Thumber,	Lanham			Prince Georg	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year			(MM/DD/YYYY) 9. B	
Director		346-30-3697 XX <sub>M 2</sub>	F 68 Y	rs. Months Days	Hours Min.	09/04/	1939	ountry) Illinois
	_ h	Usual Residence of Decedent	10c. City, Town or Loca	tion				10d, Inside City Limits
ow any		10a. State 10b. County Prince George		nbelt				1 X Yes 2 No
Aaryland 28a-f show I at once,	황	10e. Street and Number		10f. Zip Code		100	. Citizen of What Co	untry?
he Mai or 28	Director	9 Lakeview Circle		,	0770		USA	
with the ns 23a		11. Marital Status 12. Was		/as Decedent of His			14. Race - Ame White, etc.	erican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral	Never Married 2 Married 1 X Yo	es 2 No	Yes, specify Cuban		Rican, etc.)	,	White
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2 hour "natu	ted	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College	during	most of working life	. DO NOT use reti	/h = -1/	Greenbelt	
036 thin 7 ne.	Complete		4	Manager			Truck Ro	epair
5-0 lled wi Hygie I other		17. Father's Name (First, Middle, Last)			18.Mother's Name	(First, Middle, Ma Pugonow		
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than natic event, the Medical	o Be	Edward Krob  19a. Informant's Name/Relationship (Type, Print	19h Maili	ing Address (Stree			er, City or Town, Sta	ite, Zip Code)
MD 21 d 2 should l lth and Mer n 27 is man	۴	Joan B. Krob/Wife		Lakeview				0770
	ŀ	20a. Method of Disposition		osition (Name of ce	1		20c. Location - City	
Pages ent of int: 1f		Burial 2 X Cremation 3 Removed 4 Opnation 5 Other Specify:		Ltan Crema	atory 10	/10/07	Alexandria	a, Virginia
Baltimore, permit. Pages La Department of He Important: If ite	1	21. Signature of Funeral Service Licensee		Name and Address		mo PA	4739 Balt: Hyattsvil	imore Avenue
6		7 Nichelle ( //har/e 23a. Part I. Enter the disease, or complications th						Le, MD 20781 Approximate Interval
Physician M_dical	1	failure. List only one cause on each line.	nsive Atherosclerotic Car					Between Onset and Death
xaminer			as a consequence of):	4,0,000,000				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):					
	nine	cause. Enter Underlying Cause						
led nsit	Examiner	events resulting in death) Last Due to (or d.	as a consequence of):					
760, icate be executed physician and the burial - transit	ical	UNPENDED AMEND	ED					
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68 certif		nast 12 months?		Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
Box e death c the atten ed for us	Physician	1 Yes 2 No 9 Unknown 9	Inknown					
P.O. Bes that the designed by the	by P	Part II. Other significant conditions contribut	ing to death but not resulting in th	e underlying cause	given in Part I.			to the cause of death?  robably 4  Unknown
ords, P w requires t is been sign should be c	edk				<del></del>	24a. Was a		autopsy findings available
SOFC aw rec has bee	Completed			<del></del>		autops perfor	sy prior t med? death	
zal Re(iau: The certificate ector, page	S			26 Plac	e of Death (Check	1 Yes 2	2 No 1 🗸	Yes 2 No
'ital sician: is certi	Be	25. Was case referred to medical examiner?	Inpatient 2 V ER/Outpatie		Tout		Residence 6 Ot	her:
ision of Vital Rec Attending Physician: The I r death. ector: After this certificate by the funeral director, page	1: To	1 ✓ Yes 2 No 227. Manner of Death 28a.	Date of Injury 28b. Time (	of Injury 28c. Inju	ury at Work?	28d. Describe h	ow injury occurred	
ion tendin tor: A	atior	1 Natural 5 Pending 2 Accident Investigation	young Bays rouny	1_	Yes 2 No			
Division of Vital Records, bospital or Attending Physician: The law requirments after death.  Interal Director: After this certificate has been sy filled in by the funeral director, page 2 should!	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At home, farm, s	treet, factory, office	building, etc.	28f. Location (S or Town, St		Rural Route Number, City
E 2 2 E I		29a. Certifier	e <i>cify)</i> e best of my knowledge, death oc	curred at the time	tate and place, an	d due to the cause	e(s) and manner as s	stated.
To the Hos within 24 hd To the Fun completely	Medical	one) 2 Medical Examiner: On the b	asis of examination and/or investi	gation, in my opinio	n, death occurred	at the time, date	and place, and due to	the cause(s)
<b>7</b> . ½ <b>6</b> 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Me	29b. Signature and title of certifier	ner stated.		se number		29d. Date signed (	
		Q.W. /		O.C	.M.E.		October 4, 200	)7 
R (In)		30. Name and address of person who com wited		enn Street, Ba	Itimore MD 2	1201		
1- (11)			2 Degistraris Signature		Z	1201		
S Regis	talte.	OCT 0 9 2007	1. Loud					

State of Maryland / Department of Health and Mental Hygien 20734324 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 10, **Physician** 2007 11:30 A M Frank R. Lawson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick 14074 Hoover's Mill Road Rocky Ridge Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number **Funeral** Months Hours 1⊠M 2□F 91 Yrs. Feb. 12, 1916 Maryland Director 217-16-2101 Usuat Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Rocky Ridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 14074 Hoover's Mill Road 21778 Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status Black, White, etc. Armed Forces? 1 ፟**25**¥es 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Mason 6 Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: if item 27 is marked other tauty or other treumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Jeanette Perry Charles A. Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14108 Hoover's Mill Rd. Rocky Ridge, MD 21778 Michael Lawson / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place)
Restnaven Oct. 15, 12⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 2007 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Memorial Gardens 21. Signature of Funeral South Licens Resthaten Fufferal Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Parts. Enter the disease shock, or heart failure. emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lift one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Appiration **Physician** Weeks Dheumenia /Medical Due to (or as a consequence of): Examiner Vementia, Vascular Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Corona resulting in death) Last Due to (or as a con equence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9 Unknown sate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes this certificate After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: Injury 1 Natural 5 Pending n 24 hours after death.
the Funerel Director: Af 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clevinger Jr. 174 Thomas Johnson Dr. MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mon Deal Year) 2 2007

ORIGINAL

32. Pigistrar's Signature

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		1 - State Registrar			Certificate of	Death		Reg. No	007	34325
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		•	For State Registrar		Cei	rtificate of	Death	F	leg. No.	34320
	Dharini		1. Decedent's Name (First, Middle, Las		ON			2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Karen	Janice LOND	NOON	·		October	6, 2007	5:05 P M
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Deal	
	<u> </u>	200	400 Cranes Roost 5. Social Security Number 6. S		(In yrs. last birthday)	Annapol If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Anne Ar	thplace (State or Foreign
	Funeral Director			□м 21Д г	53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April 2		canada
	yland now at		10a. State 10b. County	1	Oc. City, Town or Lo					10d. Inside City Limits
	a-f sh	ctor	Maryland Anne Ar	undel	Annapo	olis				1 ☐ Yes 2 💢 No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 400 Cranes Roost	Court		10f. Zip Code 2140	9		10g. Citizen of What Co Canada	ountry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
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Maryland	uld be file Aental Hy, rked othe tic event,	To Be Completed	17. Father's Name ( <i>First, Middle, Last)</i> $I  \text{vor}$	Rorquist			18. Mother's Nam Hazel	e (First, Middle, Bonney	Maiden Surname)	
	and 2 shoralth and N		19a. Informant's Name/Relationship ( Morris London, Hu		l l	-	ost Ct.,		is, MD 214	
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Balti	permit. Departm Importa any Inju		21. Signature of Fauer Same Lice	see			ess of Facility Hebrew F		Home ngton, DC	20012
	Physician /Medical Examiner		23a. Part1. Error the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a ob.	ne death. Do not ended Pancre consequence of):	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Dealth Jan., 2002
)0°	eath certificate be executed attending physician and for use as the burial-transit	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	consequence of):	_				
68760,	cate b	Medical		d						
Box	he death certifi the attending I ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death 3 [	⊒Ectopic pregnanc ⊒ Other (specify) _	ey		23d. Date of de Month	livery Day Year
rds, P.O	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
Reco	e la has je 2	Completed						24a. Was autop	an 24b. Were a prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
ital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical	S = 1		7,41	26. Place of Dea			20.110
<u>r</u> <	ys dir	To E	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 ☐ Inpatient	t 2 ER/Outpatie	nt 3 DOA			dence 6 □Other (Spe	ecify)
n o	ffer		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo		28d. Describe h	now injury occurred	
Division or Vital Records,	or Attend after death. Director: / in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, farm, st (Specify)		]Yes 2□No	28f. Location (S City or Tow	Street and Number or R vn, State)	lural Route Number,
1	To the Hospital or Attendl within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	th occurred at the to	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. te to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier				se number		29d. Date signed (Mon	_
	10		· Nan Jake	un, m.	D	DS	53070		Oct 8,	2007
	10		30. Name and address oberson who	completed cause of dea	ath (Item 23a) (Type,	Print)	1231	Dan	Laheru M	1. D.
	Sta Regist		31. Date filed (Month, Day, Year) CCT 1 0 2	32 legistrar	's Signature	and i		)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 7 34327 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Lovern Joseph Louis 10-03-2007 9:07 AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, rince 6 course Georges Prince 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In y/s. last birthday **Funeral** Year 1₩ M 2□ F 434-76-0110 Yrs. 02-24-1951 56 Lafayette, LA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at t¥#Yes 2 No Largo Prince George's Directo Maryland 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 20774 USA 8961 Town Center Circle Unit 107B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No B1ack Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Self-Employed +06 Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna James Isadore Louis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chalana M. Louis-Brown/daughter 9715 Tulip Tree Drive Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10-10-2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dres Mo 1457 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertenene Heart Diseas **Physician** HATERIOSCHEWIC disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, beading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to Yor de à noneequence off Examiner death certificate be executed physician and the burial-transil Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Year P.O. I 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 se autopsy performed' 2 - NO Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 1 🔲 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Yea OCT 0 9 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Bev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Amend #20a&b Per FH G873 12/11/07e FF Death

Reg. NO. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 P October 6, 2007 McSparron /Medical Donald. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7181A Cimarron Court Frederick Frederick f Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 312-38-4006 68 Director Nov. 2,1938 Indiana Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified et 1 ☐ Yes 2 YNo Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 21703 death v Funeral 7181A Cimarron Court USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No "natural", or Baltimore, Maryland 21215-0036 Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physicist **US** Government Department of Health and Mental Hygie Importent: If Item 27 is marked other i any injury or other traumatic event, <u>tt</u> <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ David D. McSparron E1sa (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger W. Miller/Funeral Direct. 1621 Opossumtown Pike, Frederick, MD 21702 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Unknown Stauffer Crematory 1 ☐ Burial 2 Maremation 3 ☐ Removal from State 10/25/2007 4 ☐ Donation 5 ☐ Other (Specify) Unknown Frederick, MD Unknown 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 Port1. Enter the disease, or co. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a cause on each line. Approximate Interval Between Onset and Death Immedian Cause (Final disease or condition resulting in death) Cascinoma **Physician** Allamer /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 🎜 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 1 ☐ Yes 2 No Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 300 W. Ninth Street, Frederick, MD 21701 Dr. Robert L. Kaufmann 31. Date filed (Month, Day, Year) 0CT 12 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Physician 2:00 A. M October 9, 2007 Mitchell R. Magiday /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Health & Rehabilitation Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours June 3, 1912 New York 95 Director 091-07-8783 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Bethesda Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5225 Pooks Hill Road, Apt. 704 N U. S. A. 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines ones. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Men's Clothing 9 Years Merchant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Marks Leo Magiday 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5225 Pooks Hill Road, Apt. 704N, Bethesda, Md. Judith N. Magiday - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/11/2007 | Pleasantville, N. J. Beth Kehilliah 21. Signature of Funeral Service Licens Edward Sage Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DIFFICILE COLITIS The law requires that the death certificate be executed CLOSTRIDEUM nding physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a the 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩No 24a. Was an page 2 s autopsy performed? Yes 2 12 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0005 7124 10/10/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Truong Bao 9715 Medical Center DRive, Rockville, Maryland 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

11

32 Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Monahan 16,2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hopkins Baltimore Hospital Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 ☐ M 2 ☐ XF Days Hours August 14 1934 Virginia Director 215-30-5928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director MD Garrett Accident 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 774 Foxtown Road 21520 United States Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 ☐ Never Married 2 X Married Pages 1 and 2 should be filed within 72 mours ment of Health and Mental Hygiene. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernie Unk William Parrish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health as Important; If Item 27 Is any injury or other traconce. Mr. David Monahan, Husband 774 Foxtown Road, Accident, MD 21520 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery 10/20/07 4 □ Donation 5 □ Other (Specify) Grantsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A 710 Church St., Kitzmiller, MD 21538 Katherine Sweets 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac hours /Medical Due to (or as a consequence of): Examiner Disease years DIDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner years The law requires that the death certificate be executed Mellita the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician years attending p for use as use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, Completed by ocar 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an certificate has t irector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be No Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ours after death. neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

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ddre s of person who completed cause of

29b. Signature and title of certifig

Arjuni

eath (Item 23a) (Type, Print)

600

29c. License number

29d. Date signed (Month, Day, Year)

North Wolfe Street, Baltimore, Maryland 21287

October 16, 2007

			For State Registrar	State of M		l / Depa		of He	ealth a		ntal Hygi	ene g. No. 2007	34331
	Physicia	an	Decedent's Name (First, Middle, I	<sub>ast)</sub> ka Jack) M	lorton	MERVI	٠ς				. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g			11111/47		Town, or L	ocation of		ctober	9, 2007 4c. County of Deal	9:40 A <sup>M</sup>
	Examin	er>	Manor Care Potom					omac				Montgome	
	Funeral		5. Social Security Number   6. 216-09-0562	Sex 7. A	ige (In yrs. la 87	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. At	Date of Birth	Year 020 Co	thplace (State or Foreign
	Director		Usual Residence of Decedent									Was	shington, DC
	Marylan I-f show fied at	tor	Maryland Montg	omery		Town or Lo							10d. Inside City Limits 1 ☐ Yes 🗶☐ No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 10714 Potomac Te	nnis Lane			10f. Zip	Code 20	854		10	og. Citizen of What Co United Sta	untry? I tes
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funer	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deceden Armed Forces 1 Yes 2  If Yes, Give Year or Dates	5? ] No 		Was Deced If Yes, spec 1 ☐ Yes 2		panic Orig , Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within 72 hounders.  than "natu he Medical	Completed by	15. Decedent's (Specify only highest the Elementary/Secondary (0-12)	Education grade completed) College (1-4o	r 5+)	(Give	dent's Usua kind of wor DO NOT us tog,ra	k done du e retired)	ıring most	of working	1	16b. Kind of Business Photograp	
land 2	uld be filed Mental Hygi Irked other Itic event, t	To Be Co	17. Father's Name (First, Middle, La	st) leyer H. Me	ervis				18. Mother	r's Name (i lizab	First, Middle, N eth Bra	daiden Surname) unstein	
	nd 2 sho alth and I 27 is ma r trauma		19a_Informant's Name/Relationship Jeff Mervis / SC	(Type. Print) 11								City or Town, State, C , MD 2085	
nore,	ages 1 a nt of Hez t; <b>If item</b>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3				osition (Nam matory or o			Dat		20c. Location - City or 07 Alexand	
Baltimore,	permit. P. Departme Important any injury once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie	$\rightarrow$	Met	2	2. Name an	d Address	s of Facility	Torc	hinsky	Hebrew Fun ngton, DC	neral Home
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	A V A Y	100	4			na			Onset and Death
E4.	Examiner	Je.	Sequentially list conditions,	b	as a consequ								
B .	eath certificate be executed attending physician and for use as the burlal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequ	,							
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P.O. Box	-To the Hospital or Attending Physician: The law requires that the death certificat Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3	⊒Ectopic pr ⊒ Other <i>(</i> s <i>p</i>					23d. Date of de Month	elivery Day Year
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	slcian; Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital:		-D/Over atio	2CI DC	Othe	r·		Check only on		
on or	ding Physith.  After this funeral di	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga			28b. Time of Injury	of 3 DC	8c. Injury Work	413(140	28		ence 6 □Other (Spe ow injury occurred	∍cify)
Division	al or Attend after death. I Director: A	Certification:	3 Suicide 6 Could no determin	ZOE. Place of	injury - At hor etc. (Specify	me, farm, st	reet, factory	, office		28	8f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,
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	5		30. Name and address of person w	ho completed cause of	f death (Item	23a) (Tvne	Print)					10/0/07	
		11 3	Surita Bh	ogavilli	1147	52	Cher	ryl	uaf	- ten	vale s	ilverson	ingrinzogo
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Physician Moders  Anne Arundel  Examiner  Funeral Director  By Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Agrand Ag				For State Registrar		State of Ma	ryland /	Depa Cer	artment of H rtificate of I	ealth and Death		giene Reg. No.	2007	34333
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  Pablo Argeles, M.D. 2001 Medical Parkway Annapolis, MD. 21401  State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		n 24 I	edic	(Check only 2 Med one)	ical Exe	miner: On the basis of and manner sta	f examination ated.	and/or in	ivestigation, in my o	pinion, death occ	curred at the time	, date and	I place, and due	o to the cause(s)
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  Pablo Argeles, M.D. 2001 Medical Parkway Annapolis, MD. 21401  State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		To t To t	Σ	29b. Signature and title of ce	rtifier	/			29c. Licens	e number		29d. Da		
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Sp		The second second						7nnn==	1 - 200	21 /	. / In1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Carrie Massey 2007 October 7:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 M 2 3 F Director 245-36-2245 81 March 28, 1926 South Carolina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1- Yes 2 No Director Maryland | Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 5900 Middleton Court 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clarence McDowell Martha Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Middleton Court Temple Hills, MD 20748 Betty Jones - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Oct 11, 2007 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner end Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

cr (3)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TEMESGEN

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D46576

6104 OLD BRANCH AVE, TEMPLE HILL MO, 20748

29d. Date signed (Month, Day, Year)

		4	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtmei <i>tifica</i>	nt of He te of E	ealth and Death	Mental H	ygien <b>e</b> Reg. No.	007	34335
			1. Decedent's Name (First, Middle, Last)						2. Date of D	Death Day	Year	3. Time of Death
	Physici /Medic		Peggy Louise Norw	rish					Octobe			2:30 A M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City	, Town, or	Location of Deat	h	4c.	County of De	ath
		20	3533 Garrett Hwy.			0ak	land			G	arrett	
*	Funeral		Social Security Number     6. Sex		iast birthday)	If Unde	r 1 Year	If Under 24 Hrs Hours Min.	8. Date of E	Birth Day, Year)	9. Bi	rthplace (State or Foreign Country)
	Director		217-30-2123	M 2 XF 75	Yrs.	1910111113	Days	110013	Dec.			ryland
	p ,		Usual Residence of Decedent	10.00								
	aryla shov	_	10a. State 10b. County		y, Town or Lo							10d. Inside City Limits
	8e-f	cto	VA Augusta	Lyı	ndhurst							1 ☐ Yes 2 🔀 No
	or 2	Director	10e. Street and Number			10f. Z	p Code			10g. Citi	zen of What C	Country?
	23a		1830 Mt. Torrey F	Road		2	2952			Uni	ted St	ates
	eme eme	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Dece Yes, sp	edent of His	spanic Origin? (S n, Mexican, Puer	pecify Yes or ! to Rican, etc.)	No-	<ol> <li>Race - Arr Black, Wh</li> </ol>	
20	or i	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	1	Yes	2 🕅 No	Specify:			Specify:	
9500-61212	hours atter death with the Maryland Lural', or Itema 23a or 28e-f show at Examinat must be multiss at		3 ☐ Widowed 4 🕅 Divorced	Year or Dates:							W	hite
ÿ	"nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	kind of w	ork done di	uring most of wo	rking	16b. Ki	ind of Busines	s/Industry
7	han han	ш	Elementary/Secondary (0-12)	College (1-4or 5+)			se retired)			M = 1	dical O	cc:
N	Hygie ther I		17. Father's Name (First, Middle, Last)		Recep	tion		18. Mother's Na	me (First Mida			111ce
בב	tall be do do do do do do do do do do do do do	Be		. C				Grace M			Sumamer	
$\frac{8}{5}$	i Mer i Mer nark	မှ	Lee Benjamin Shaf				10					
Maryland	12 st n and r ls n		19a. Informant's Name/Relationship (Ty	7-		_		nd Number or A				
ຜົ	l and lealth im 27		Louise Norwish, I	Daughter				ey Road,	Lyndhu	_		952
Ö	t of t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Dispo cemetery, cren	natory or	other place	9)	Date	20c. Lc	ocation - City o	r rown, State
E	men tant: jury	١,	4 □ Donation 5 □ Other (Specify)	Cui				ory   10/			perland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28e-f show entry injury or other treumatic event, the Medical Examinat must be multified at ance.		21. Signature of Funeral Service License	99	22	Davi	nd Addres:	s of Facility Burdock	Funera	1 Hon	ne, P.A	
	σΩ = • α		Katherine D	weiter		21 N	. Sec	ond St.	, Oakla	nd, M	D 2155	0
		8	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not ente	er the mo	de of dying	), such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End Stage	Heart I	)isea	ise					Onset and Death Years
	/Medical	ï	resulting in death)	Due to (or as a consec								
- 1	Examiner		Sequentially list conditions	).								
W. C.	φ <i>=</i>	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	uence of):							
	cate be executed physicien and the burial-transit	Examiner	that initiated events	3.								
Ď,	e exe	Ë	resulting in death) Last	Due to (or as a consec	(uence of):							
8/60	physic physic the b	dicai		d								
9		Mec	IF FEMALE:									
ROX	death certifi e attending I id for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		Ectopic (	oregnancy			1	23d. Date of d Month	elivery Day Year
	0 0	Sici	1 □ Yes 2 DXNo	4 Pregnant at time of o 9 Unknown	death 5□	Other (s	pecify)			-	WORLD	Day Todi
J.	The law requires that the sie has been signed by thoage 2 should be detache	Physician/Me	9 Unknown									
	res tha igned b	þ	Part II. Other significant conditions cor	nthbuting to death but not res	sulting in the u	nderlying	cause give	n in Part I.				to the cause of death?
Division of Vital Records,	w require been si should b	ted			_				11	Yes 2	∐No 3∐.	Probably 4 XUnknown
ပ္ပိ	as be	pie							24a. W	as an topsy	24b. Were	autopsy findings available completion of cause of
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<u>ta</u>	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					26. Place of De				
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0	ding Ph. h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury Work	at	28d. Describ			
Ö	tendin death. tor: Af the fur	atic	1 ZNatural 5 ☐ Pending 2 ☐ Accident investigation	(monun, bay roan)	,۵/,	М		Yes 2 □ No				
<u> </u>	er de	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, facto	ry, office		28f. Location	Street ar	nd Number or	Rural Route Number,
ā	rs aft el Di	Certification:		Sandary, Stc. (Speci					2.1, 01	, Diale	,	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certifice completely filled in by the funeral director.		29a Certifier 1X Cortifying Physical Exami	elician: To the best of my kniner: On the basis of examina	owladge death	i odeuma	d at the tim	ie, date and plan	s, and due to t	na cause(s	) and manner	as stated
	in 24 he F plete	edicai	one)	adon and/or in	vestigatio	n, iii my op	Januari, death occ	uneu at the th	e, uate and	u piace, and d	ne in the remad(s)	
	To To t	Σ	29b. Signature and title of certifier			2	9c. License	number		29d. Da	te signed (Mo	nth, Day, Year)
			Yaul Dans	et neels	一个	9	H261.	54		10	/18/07	
			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)						
		5	Dr. Paul Daniel	Miller, 69 Wo	1f Acr	es D	rive,	0akland	1, MD 2	1550		
77.7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	6						
	Regist	rar	00119	2007	202	all non	09 0					

State of Maryland / Department of Health and Mental Hygiene 2007

			for State Registrar	State of	Marylan	id / Depa	artmen rtificat	t of H e of L	ealth a Death	and M		giene Reg. No.	200	7	3433	36
	Physicia	an	1. Decedent's Name (First, Middle,	Last)							Date of De Month	Day		'ear	3. Time of Deat	
	/Medic		Wilbur Paul	Novak							Octobe	r 5	200		1:32 A	М
	Examin	er	4a. Facility Name (If not institution,		per)		4b. City,		Location o	of Death			County of Anne		ndol	
	- harman hilliphya	-	4187 Solomons Is 5. Social Security Number 6		. Age (In yrs.	last birthday)	If Under	Harw 1 Year	If Under	24 Hrs.	8. Date of Birt				lace (State or For	reian
	Funeral Director		468-07-1859	1 <b>X</b> M 2□F	89	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da June 26	y, Year)	18	Coun Minr	try)	0.9
	and the same		Usual Residence of Decedent													
	rylan how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside City Lir	
	e Ma 8a-f s ptifled	Director	MD Anne Ar	undel		Edg	rewate								1 □ Yes 2√2	1140
	vith th	Dire	10e. Street and Number				10f. Zip					10g. Citi	zen of Wh		try?	
	J within 72 hours after death with the Maryland jiene. Jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	erai	3617 Solomons I	sland Rd.	ent Ever in II	9 12	Was Deco	210		ain? /Sn	ocify Voc or No		USA 14. Race		an Indian	
_	ter de item	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Ford	es?				n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)			White,		
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Z	within 7 iene. • than "r	nple	Elementary/Secondary (0-12)	College (1-	for 5+)	life.	DO NOT u	se retirea	) -			a.		- 1	- 23	
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and	ild be filed tental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, La	ast)				İ			e (First, Middle,		Surname,	,		
$\leq$	should ind Men marke	은	Emil Novak  19a. Informant's Name/Relationship	(Time Print)		19b Mailir	na Address	(Stroot	Mary		Zzechk		r Town S	tata Zin	Code	
Za			Shelly Ford / c			3617	-						ter,		21037	
<u>ნ</u>	es 1 and 2 of Health Item 27 i		20a. Method of Disposition			Place of Dispo	osition (Nar	ne of	i		Date		cation - C	_	wn, State	
ıtımore,	Pages nent of I int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from S ecify)	rare i	-	-			10/0	06/2007	Ale	exand	lria	, VA.	
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	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on ea	ch line.		92					rrest,			Approximate Interval Between Onset and Death	n n
,09/80	death certificate be executed e attending physician and for use as the burial-transit	dical Examiner	resulting in death)  Se_uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consec r as a consec r as a consec	puence of):	pone	rry	as	rei	H					
O. Box 6	at the death certific by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of o	al death 3	⊒Ectopic p ⊒ Other (s <sub>#</sub>		'				23d. Date Mont		ery Day Year	
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition			_	inderlying o	ause give	en in Part I		23e. Did t			oute to th	ne cause of death pably 4.☑Unkn	
င္ပ	w req	Completed									24a. Was	an	24h W	ere auto	psy findings avail	lable
Ä	9 <u>£</u> 9	дшо									auto perfe	psy ormed?	pri de	ior to co ath?	mpletion of cause	of
VItal			25. Was case referred to medical						26 Place	of Deat	1  Yes h (Check only o	2 No	111		<sup>2□№</sup> ssisted	
	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ <b>X</b> No	Hospital: 1 ☐ In	patient 2	ER/Outpatie	nt 3 □ D0	Oth					6 XOther	(Specif	voliving	
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time o	of :	28c. Injur Worl			28d. Describe					
VISION	ath. ath. r: Af	atio	1 Natural 5 ☐ Pending investiga	tion	, Day Tour,	,,	М		Yes 2□	No						
	e Hospital or Attending P 24 hours after death. 9 Funeral Director: After t etely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad Zoe. Flace	of injury - At h g, etc. <i>(Speci</i>	ome, farm, st fy)	reet, factor	y, office			28f. Location ( City or To			r or Rura	i Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (		Physician: To the l xaminer: On the ba and mann	sis of examina											
	To the Ho within 24 To the Fu	Ň	29b. Signature and title of certifier	. 1/.					e number				•		Day, Year)	
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			= State Registrar	tate of Maryland	I / Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death	R	eg. No.	7	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	04	JEN	5		2. Date of Dea Month	Day Y	Sear 7	3. Time of Death 2124 M
	Examin		4a. Facility Name (If not institution, give street  Anne Arundel Medica  5. Social Security Number 6. Sex		ot highdayl		Location of Death  napolis If Under 24 Hrs.	9 Date of Right	4c. County of	rund	
	Funeral Director		578-32-2587 1 M			Months Days	Hours Min.	8. Date of Birth (Month, Day 1/9/192	3 W	Countr	nce (State or Foreign y) ngton, DC
	death with the Maryland rms 23s or 28s-f show f.must be notified at	Director	10a. State		Town or Loc			1	0g. Citizen of W		d. Inside City Limits 1 ☐ Yes 2√☐ No
0500-6	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at	by Funerai	2 Narried 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 222No If Yes, Give Year or Dates:	lf.	210 Vas Decedent of Hi	32 ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No-	USA 14. Race	- America White, e	n Indian,
アにコン	od within 72 hours after giene. er than "naturel", or Ite r the Medical Examina	Completed	15. Decedent's Education (Specify only highest grade continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the continued in the cont		(Give i life. D	ent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work l)	1	16b. Kind of Bus		ustry
Jand	12 should be filed within n and Mental Hygiene. 7 ie marked other than "reumatic event, the Mec	To Be (	17. Father's Name (First, Middle, Last) Raymond Owens				18. Mother's Name Ethel F		Maiden Sumame	)	
Mar	and 2 sho Balth and I n 27 te ma		19a. Informant's Name/Relationship (Type, Diego Cantu Compan			g Address <i>(Street a</i> ocust Tra	and Number or Rura  il Crown		r, City or Town, S  MD 2103		Code)
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commerciate Cause (Final disease or condition resulting in death)	ons that caused the death. ause on each line.  Due to (or as a consequence)	1 one	er the mode of dyin	g, such as cardiac		est,	1	Approximate Interval Between Onset and Death 2
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CO. BOX &	ath certif stending for use a	Physician/Med	in the past 12 months?	If yes, outcome of pregnan 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy			23d. Date Mont		y Day Year
ras, r	w requires that the de been signed by the should be detached	ام	Part II. Other significant conditions contrib	uting to death but not resul	lting in the ur	nderlying cause give	en in Part I.	23e. Did to			e cause of death?
al Records	The lay ele hes page 2	Completed						24a. Was a autop pertor	sy pr m_opd? de	ere autopior to comeath?	sy findings available apletion of cause of
on or vital	> @ D	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp  27. Majner of Death 1 Natural 5 Pending 2 Accident investigation	1 Interpatient 2 LE	R/Outpatien 28b. Time of Injury	28c. Injun Work	4 Li Nuising Ho	me 5 Resid	ence 6 Othe		)
DIVISION	he Hospitel or Attending Ph n 24 hours efter death. he Funerel Director: After th pletely filled in by the funeral	Certification;	2 □ Suicide 6 □ Could not be □	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rural	Route Number,
	To the Hospi within 24 hou To the Funer completely file	Medicai	2.0 Confider 1 Conting Physicial (Check only one) 2 Medical Examiner	and To the bast of my know On the basis of examinati and manner stated.	nedge death on and/or inv	restigation, in my o	na data and place pinion, death occur	and due to the r red at the time, o	date and place, a	ner as sto nd due to	the cause(s)
		)	29b. Signature and title of certifier	Harta.	w	29c. Licens	vi438		29d. Date signed	(Month, L	2007
	160		30. Name and address of person who comp	at ENA W	1446	"D'EFENS	Elhanw	my Ana	APOUS W	nu	401
	Sta Registi		31. Date filed (Month, Day, Year) 0CT 1 0 2007	37 Registrar's Signat	rre de	de					

State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M10/4/2007 **Physician** Rose M. Prugh 7:30pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Futurecare Chesapeake Arno1d 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10/4/1918 Birthplace (State or Foreign Country)

A **Funeral** 1 □ M **XX**F Months Days Hours Min 206-07-8492 89 Director Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location r 28a-f ehow 10d. Inside City Limits MD Anne Arundel Arno1d 1 ☐ Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be a 305 College Pkwy. 21012 USA death by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Hauth and Mental Hygiene. Importent: if item 27 is marked other them 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 10 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White Specify: 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Sewing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John McHenry Bernie Irene Whitacre 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Prugh Son 744 Dividing Rd. Severn Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/8/2007 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 6 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive uears /Medical Due to (or as a consequence of) Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the buriat-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) P.O. I 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has rat director, page 2 perform 1 | Yes 2 | 1√0 s after death.

• Director: After this certificate in by the funeral director, p or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Tatural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who Registrar

State of Maryland / Department of Health and Mental Hygiene 34339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 2007 7:35 AM 30 DANISE PALMER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY 7907 Baden Lock Way, #104 Gaithersburg 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 28 F 36 Sept.6,1971 Maryland 215-92-5246 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD Montgomery Gaithersburg 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7907 Baden Lock Way, #104 20879 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Willow Woods Elementary/Secondary (0-12) College (1-4or 5+) Secretary Condo 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elwood Davis Edna Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20879 19a. Informant's Name/Relationship (Type. Print) 7907 Baden Lock Way, #104, Gaithersburg, MD Edna Offord (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation Riverdale, MD *K*iverdale Pk Cre 10/11/07 4 Donation 5 ☐ Other (Specify) of Funeral Service 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final COMMICO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duz to (ur as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ N Medical Certification: To After this 28c. Injury at Work? 27. Manner of 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCHOBER 03,2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN RP#435, Swer Sprugue 1400 FOREST 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 200 Year October **Physician** 4:00 P M Palmer Addie /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F 82 152 16 5155 April 13 1925 South Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County Y☐Yes 2☐No Bethesda Funeral Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4521 East West Highway # 410 20814 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Craig Jesse Rae ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10555 Tralee Terrace Damascus, Maryland 20782 Katherine Busey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Md. National Cemetery 10/8/2007 | Laurel , Maryland 4 □ Donation 5 □ Other (Specify) Sansture of Funeral Service/Licen 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): TRACT INFECTION Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner , ... Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? res 2 14 No 2 **N**io 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0005 7124 10/4/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao MD 9715 Medical Center Drive Rockville, Maryland 20850 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 0 9 2007

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Palmer, ADDIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 34341 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Robinson Month Alice September 17:43 27,2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore City The Johns Hopkins If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🖾 F Days Hours Oct. 30, 1940 Shelby, 66 319-36-8859 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Edge Creek Lane 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Marned 1 ☐ Yes 21 No Specify: Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Head Start Teacher</u> Private 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lucile Jones Bailey Robinson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 10504 Jib Court Cheltenham, MD 20623 Donald P. Robinson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Oct. 8, 2007 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. S mature of Foreral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road, NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Immediate Sal se (Final disease or condition resulting in death) 9 hours Hypotension Due to (or as a consequence of): 10 hours Figure Respiratory Distress Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration Due to (or as a consequence of): 24 hours Lleus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chamic myelomonocytic teukemia Panhypopituitarism 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Uninary Tract Infection 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27 Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner ettending physicien and for use as the burial-transit

**Physician** 

/Medical

Examiner

**Funeral** 

Director

in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filled within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ns any injury or other traumatic event, the Media 2006.

**Physician** 

Examiner

/Medical

Maryland 21215-0036

Baltimore,

Directo

Funeral

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Be Completed

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To the Hospital within 24 hours a To the Funaral D

Physician/Medical Completed by this certificate within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director. Be Certification: To Medical

> State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier medical Doctor

29c. License number RES - 000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) September 27, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) MD

Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, Maryland

32. Registrar's Signatu

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be

10-01 P.O. Division or Vital Records, Edwin Solomon:

Baltimore, Maryland 21215-0036

Og29 Am

Box 68760,

To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

State Registrar

31. Date filed (Month, Day, Year) 11 2007 OCT

29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DR. ATUL ROHATGI, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND

29c. License number

D006 302

29d. Date signed (Month, Day, Year)

07

20850

State of Maryland / Department of Health and Mental Hygiene 2007 34343 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 3:00 p<sup>M</sup> 2007 October Helen L. Schulman /Medical 4c. County of Death 4h City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Silver Spring 3156 Gracefield Road, OP421 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕱 F Yrs 95 New York Director April 17, 1912 248-56-5077 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" -- " any injury or other traumatic ever-10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐Yes 2 No Director Prince George's Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 U.S.A. 3156 Gracefield Road, OP421 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify. Specify: 2 Year or Dates: White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Berger Louis Werner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1009 Mondrian Terrace, Silver Spring, Maryland 20904 Merle Ruth Heiden - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/15/2007 Brentwood, Maryland Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗆 No 1□ Yes certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 X Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 10, 2007 D34590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, Maryland 20904 Roy Fried, M.D.,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Pegistrar's Signature

32.

2007

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

Takoma Park

If Under 1 Year | If Under 24 Hrs.

2. Date of Death

Month

October

State of Maryland / Department of Health and Mental Hygiene Reg. No. Day 11:36 ам 2007 4c. County of Death Montgomery Birthplace (State or Foreign
Country) Palestine 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Food Preparation 20c. Location - City or Town, State Silver Spring, Maryland Approximate Interval Between Onset and Death 24 hours 20 years 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) October 11, 2007

State Registrar tre

31. Date filed (Month, Day, Year)

UCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2007

1 - For State Registrar

5. Social Security Number

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

Raki Kustandi Said

Washington Adventist Hospital

6. Sex

4a. Facility Name (If not institution, give street and number)

Smith S. Ho, M.D., 7610 Carroll Avenue, #280, Takoma Park, Maryland 20912

32 Registrar's Signature

D21900

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Khea /Medical October 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Medical Center Baltimore Iniversity 0 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🔀 F 85 Maryland Director 5-19-1922 215-18-5054 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at MD Anne Arundel Annapolis Director 1 ☐ Yes 2 TNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 680 Americana Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 153 es 2 No 43-44 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1- Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**€** No Specify: White Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 12 should be filed w h and Mental Hygier 7 is marked other th Purchasing Agent USNA permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Thiman Helen Jacobs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Richard Bates Son 10500 Rockville Pike #806 Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kneseth Israel 10/9/2007 Annapolis, MD 21. Signature of Funeral Sortice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. - J. 175 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Brodycardia /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any least conditions, if any least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examine Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending n 24 hours after death.
he Funeral Director: Af
pletely filled in by the ful investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To th. within 2. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 7,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leudoy Sardanay, MD 22 Greene St. Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 0 2007 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68/60,	ò	Baitimore, Maryland 21215-0036
the Hospital or Attending Physician: The law requires that the death certificate be executed	Ph //	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan
	y: Ma	Department of Health and Mental Hygiene.
		Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show
pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia ic:	any injury or other traumatic event, the Medical Examiner must be notified at

Funeral Director

1	<ul> <li>State</li> <li>Registrar</li> </ul>						Certi	ficate of	Death			Reg.	No. 2	101	3434	O
1		e (First, Midd.	le, Last)										Day	Voor	3. Time of Death	
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4:			-				4			of Death				-	eorge's	
					7. Age (In yrs 90		N N		If Under Hours	24 Hrs. Min.	(Month.	Day, Ye	ar) 916	Cou	ntry)	n
U	Isual Residence of	Decedent														
1	0a. State MD			orge'		City, Town			lboro	)					10d. Inside City Limits 1 ☐ Yes 2X No	
1.			ding	g Road				10f. Zip Code 20	)772			10g.	Citizen of	What Cou	ntry?	
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2	21. Signature of 5	nefal Servi	Licenso	916	1343	)	22. N	Name and Addr		-	ne, PA					
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i	cause. Enter Unde	erivina	Į°	)												
	that initiated event	S	c	Due to	(or as a conse	equence of	f):									_
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1 .	23b. Was deceder in the past 12 1 ☐ Yes 2	months?	2:	1□Live 4□Preg	birth 2 □ Fe nant at time of	etal death			су			_			very Day Year	
	Part II. Other signi	ificant condit	tions con	ntributing to	death but not re	esulting in	the unde	erlying cause g	iven in Part	I.	23e. D	id tobac	co use coi	ntribute to	the cause of death?	
	Atria	1 Fibr	illa	ition							1	☐ Yes	2 <b>X</b> No	3 □ Pro	bably 4 Unknow	n
-   -											ai pe	utopsy ertormed	1?	prior to c death?	ompletion of cause of	
	25. Was case refe	rred to medic	al					-	26. Plac	e of Dea			I NO	T I Tes	24L 110	_
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-	1 🖾 Natural	5 Pendi							ury at ork?				-			
	3 ☐ Suicide 4 ☐ Homicide			28e. Plac build	e of injury - At ding, etc. <i>(Sp</i> e	home, farr	m, stree	t, factory, office	3		28f. Locatio City or	n (Stree Town, S	t and Nun Itate)	nber or Ru	ral Route Number,	
1	29a. Certifier (Check only one)			ner: On the	basis of exami											
4	29b. Signature and	d title of certifi	ier	6								29d.	-		n, Day, Year)	
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	4 4 5 - U 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. Decedent's Name  4a. Facility Name (I Larkin  5. Social Security N  5. 77-16-5  Usual Residence of 10a. State  MD  10e. Street and Nu  5810 Gree  11. Marital Status  1 Never Marn  3 Widowed  (Special Security N  12. Street and Nu  13. Widowed  (Special Security N  14. Marital Status  1 Never Marn  15. Widowed  17. Father's Name  18. Reverdy  19a. Informant's N  19a. Informant's N  19a. Informant's N  19a. Information  21. Signature of F  12. Signature of F  13. 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Sliker	Registrar   Continued   Cont	Registrate   Continues   Con	The December Name (First, Middle, Last)   Day Oct   S   Date of Death   Day Oct   S   Day Oct   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Registrary   Reg	Decembers Survey (Prior, March Lard)   Lard Kin Chase   Nursing Home   de City, Toon, or Localita of Data   Day Open   2.3 Time of Double   Lark Kin Chase   Nursing Home   de City, Toon, or Localita of Data   Day Open   2.3 Time of Double   Day Open   Double   Day Open   Double   Day Open   Double   Day Open   Double   Day Open   Double   Day Open   Double   Day Open   Double	
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			1 - For State Registrar		ryland / Depa <i>Cel</i>	rtificate of L	Death		g. No.	34347
	Physici	an	1. Decedent's Name (First, Middle, Li					2. Date of Death Month	9, 2007 Year	3. Time of Death
	/Media	al	Lila J.  4a. Facility Name (If not institution, gi	Willis		4h City Town or	Location of Death	October	9, 2007 4c. County of Death	10:40 A™
ı	Examin	er	Vindobona Nursin				ck Height	s	Frederic	
I	Funeral Director		226-52-0369		(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 31,	Year) 9. Birth Cou 1915 Vir	pplace (State or Foreign intry) ginia
	death with the Maryland ms 23a or 28s-f ehow (must be notified at	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the Market	Director	Maryland Freder  10e. Street and Number	rick	Monro			100	- Civi	1 ☐ Yes 2 ☒ No
	3a or	i Di	4630 Lynn Burke I	Road		10f. Zip Code 21770			g. Citizen of What Co. Jnited Stat	-
	oms 2	Funerai	11. Marital Status	12. Was Decedent Example Forces?	ver in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp		14. Race - Amer Black, White	ican Indian,
7036	be filed within 72 hours after death with the Manylan tal Hygiene. d other than "natural", or Items 23a or 28s-1 ehow avent, the Madical Examinat must be notified at	δ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		Tribati, Sio.,	Specify: Wh	
9500-61212	within 72 h ene. than "natu he Wedical	Completed	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1-4or 5+	life. I	dent's Usual Occupa kind of work done o DO NOT use retired,	ation furing most of work i)	ing	5b. Kind of Business/l	ndustry
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	should and Men a marke umatic	2	19a. Informant's Name/Relationship	-	19b. Mailir	ng Address (Street a			City or Town, State, Z	ip Code)
ĭ Ma	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		Linda Slattery /	Granddaught	er 4630	Lynn Bur	ke Rd. Mo			,
more,	permit. Pages 1: Department of He Important: If Item eny Injury or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec		20b. Place of Dispo cemetery, crea Rest Memorial	sition (Name of patory or other place naven Gardens	Oct. 200	12,	ederick, M	
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			23a. Part . Enter the disease, or cor shock, or heart failure 1 st ont	nplications that caused to	he death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	gestive consequence of): Pneum o	Heart	Fail	we		Onset and Death YEARS
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	nsit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					YEARS
	an and	Exa	that initiated events resulting in death) Last		on equence of):	. 0-				
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O. BOX 68/60	ne death certificate be executed the ettending physician and shed for use as the burial-transit	ed	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
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		For State Registrar	State of Maryland		artment of H rtificate of I			iene <sub>eg. No</sub> 200	7 34	+348
		Decedent's Name (First, Middle, Last)					2. Date of Deat	·la	3. Tim	ne of Death
Physic		John Lovelle	Withers				Octobe	er 7, 2	007 9:	57 рм
/Medi Examir		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death	1	4c. County of	Death	
		3417 St. Leonard's	Court, #111B		Si	lver Spr	ing	Montgo	mery	
Funeral Director		5. Social Security Number 6. Sex 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 8	Year)	9. Birthplace (Sta Country) North	ate or Foreign Carolir
aryland show d at	١	Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	ocation				I	le City Limits
e Ma Ba-f s	Director		ntgomery	Sil	ver Sprin	g				
ith thou	Dire	10e. Street and Number			10f. Zip Code	00006	1	0g. Citizen of Wh		
ath w		3417 St. Leonard				20906			USA	
be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No If Yes, Give 1941— Year or Dates:	47	Was Decedent of H If Yes, specify Cuba 1 □ Yes <b>x%</b> No	ispanic Origin? (S an, Mexican, Puerl Specify:	pecity Yes or No- o Rican, etc.)	Black,	- American Indiar White, etc. Black	Π,
hou attura	ed	15. Decedent's Educa	tion		dent's Usual Occup			16b. Kind of Busi	iness/Industry	
within 72 iene. than "na he Medic	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired	1)	_	U.S. Age	-	
filed w Hygiei other th	S	45 5 H   1 N   45 H   15 H   1 - 0	5+	F'O:	reign Ser		ne (First, Middle, i	Internat		everop
intal H ed ott	Be	17. Father's Name ( <i>First, Middle, Last</i> ) Robert Baxter Wi	thers				e Elizab	· · · · · · · · · · · · · · · · · · ·		
ss 1 and 2 should be file of Health and Mental Hy Item 27 is marked oth r other traumatic event	To	19a. Informant's Name/Relationship (Type Daisy P. Withers/	*		ng Address <i>(Street</i> 17 St. Le	and Number or Ru	ıral Route Numbe	r, City or Town, S	tate, Zip Code)	2090 ring,
jes 1 an t of Heal if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20b. Pl	ace of Dispo emetery, crea	osition (Name of matory or other place	ce) Oct	ober 9,	20c. Location - C		
Pag ment ant;		4 □ Donation 5 □ Other (Specify)	Met		itan Crem		007	Alexandr	ria, Vir	ginia
permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signal of Pineral Service Licensee	to	F:	2. Name and Addre rancis J. 00 Univer	Collins sity Blv	d, W, Si	lver Spr	ic.	20901
Physician /Medical	l	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Prostate Ca	ncer	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approx Interval Onset a 16 y	rimate I Between and Death Cars
Examiner			Due to (or as a consequ	ience or):						
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisase of injury	Due to (or as a consequ	ence of):						
ficate be executed physician and s the burial-transit	al Exar	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):						
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requires that the death certificen signed by the attending prould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date Mont	of delivery th Day	Year
luires that the de n signed by the a Id be detached f	by	Part II. Other significant conditions cont	ibuting to death but not resu	Ilting in the u	nderlying cause giv	en in Part I.		bacco use contrib		
e law has b je 2 sl	Completed						24a, Was a autop perfor 1 Yes	sv pr	/ere autopsy findi ior to completion eath? □Yes 2□ No	of cause of
	(D)	25. Was case referred to medical				26. Place of De	ath (Check only or			
Physician: this certific	OB	examiner?	spital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3□ DOA Oth	or.	dome 5 A Resid		r (Specify)	
		27. Manner of Death	28a. Date of Injury	28b. Time o				ow injury occurre		
or Attending Fafter death.  Director: After in by the funera	Certification:	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year)  28e. Place of injury - At ho building, etc. (Specify	Injury me, farm, st	M 1□	kr Yes 2∐No	28f. Location (S City or Tow	treet and Number n, State)	r or Rural Route	Number,
prita ours neral		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of my known.	wledge, dea	th occurred at the ti	me, date and plac	e, and due to the	cause(s) and man	nner as stated.	use(s)
To the Hos within 24 ho To the Fur completely	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Dav. Ye	ear)
To with	100	205. Gignature and title of certifier	, 50			400	Ι.	101		,

30. Name and address of person who completed cause of death (ltem 23a) (Type, Print) George A. Sotos, MD 9707 Medical Center Drive, #300, Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year) OCT 1 0 2007



10+1

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 34349 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10-04-2007 RAYMOND WRIGHT 1:41 P /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01-20-1946 9. Birthplace (State or Foreign **Funeral** Months Days Caroline Co., VA 577-62-2504 61 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 21s marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show hoffined at the Thannatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Funeral Director ₩Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r 235 "V" Street, N.W. 20001 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status r than "natural", or iter the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ☐ Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Bertha Greene ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. 235 "V" St., N.W. Washington. D.C. 20001 Tihitah Wright/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 10-15-2007 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility のんか Mo/457 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC REWAL FAILURE 1 Yes 2 No 3 Probably 4 Wunknown Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HYPERTENSION perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 es 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40324 OCTOBER 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar 0CT 0 9 2007

31. Date filed (Month, Day, Year)

JODRIE MD

32. Registrar's Signature

7503 SURRATTS ROAD, CLINTON, MARYLAND

20735

State of Maryland / Department of Health and Mental Hygiene 34350 State Registrar Amend#29d.PerPhys.PGC10-9-07cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Angela K. Woodland October 4 2007 17:04p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F 217-19-5681 Director 30 21, 1977 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland | Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7769 Riverdale Road, #102 20784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetologist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard L. Woodland Linda Jones ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Woodland - Mother 7769 Riverdale Rd., #102, New Carrollton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/12/2007 | Brentwood, Maryland 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DOOROW /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a nonsecuance of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Onknown Month Day Year 5 Other (specify) detached 9□Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform-1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 214 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မှ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erin Smith, M.D., 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 9 2007 Registrar

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saltimore,	ges 1 t of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place cem	e of Dispos etery, crem	ition (Name of atory or other place	е)	Date 2	0c. Location	- City or To	own, State
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)_	(2)		30. Name and address of person who completed cause of George C. Willis Z	death (Item 23	3a) (Type, F Gree	Print)	Baltima	ore MD	2120	1	
	Sta Registr		George C. Willis 2  31. Date filed (Month, Day, Year)  OCT 0 9 2007  Size A 2007	trar's Signature	e de	·				· · · · · · · · · · · · · · · · · · ·	
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			For	Sta	ate of I	Marylan					nd M	ental Hy	giene			
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lai yia	and Mental Hygiene. Is marked other than aumatic event, the Me	ဥ	19a. Informant's Name/Relations				19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City or	Town, State,	Zip Cod	de)
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Pages	Department of Health Important: If Item 27 any Injury or other tr. once.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		al from Sta	ate	rt Linco	-	•	' i	0/12/	/2007	Brei	ntwood,	Marv	land
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The law requires that the death certific	this certificate has been signed by the aftending pal director, page 2 should be detached for use as		Part II. Other significant condit	ions contribut	ing to deat	th but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	obacco us	se contribute	to the c	ause of death?
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	ector	ifica	3 ☐ Suicide 6 ☐ Could	not be 28	e. Place of	f injury - At ho	ome, farm, sti	reet, factory	y, office			28f. Location	Street and	d Number or	Rural R	oute Number,
5 2	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)							City or Town, State)						
DIVISION VICA	within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	edical (	29a. Certifier 1 ☐ Certify (Check only one)	ing Physician	on the bas	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	id place, ith occur	and due to the red at the time	cause(s) , date and	and manner place, and d	as state ue to th	d. e cause(s)
the c	ithin (	Med						c. License	icense number 29d.				d. Date signed (Month, Day, Year)			
F			Loveen		run	raug	MB		D5	952	ч		Oc=	tober	9	, 2007
	0		20. Nome and address of pores	n who complet	ted cause	of death /Iten	n 23a) (Tyne	Print)			1					
			LOVEEN J. Pu	THUM	HANI	A , 3111	O GRA	CEFIE	LDR	OND	SILV	ERSPR	146	MD 20	904	<u> </u>
	Sta Registi		31. Date filed (Month, Day, Year OCT 1 0	r)	3 Rec	gistrar's Signa	ature don	util .								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 17

					. y . a a .	Certifica	te of	Death		Reg. No.	U/ .	34353	
	Dharia		1. Decedent's Name (First, Middle, Las	")					2. Date of De Month			3. Time of Death	
	Physic /Medi		Kosalje K	, Allisor	)				October		Year O7	9172 AM	
1	Exami		4a. Facility Name (If not institution, give					4b. City, Town, or I		4c. County			
				Core Cen		ar to the latest	er 1 Year	If Under 24 Hrs.	rille		1 timo		
	Funeral Director		210-30-5852	x /. Age □M 2√∑F	(In yrs. last bii 91		Days	Hours Min.	(Month, Da	in ly, Year) 17,1916	9. Birthplace Country) Mary	e (State or Foreign 1and	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					10d.	Inside City Limits	
	Maryl	ō	Maryland Bal	timore			D1	ville				1 ☐ Yes 2 💢 No	
	r 28a	Director	10e. Street and Number	CIMOTE			p Code	viite		10g. Citizen of V	Vhet Country	?	
	th wit	a	8820 Walther Blvd	., Apt 130	)3			21234		II	. S. A		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Dece	edent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No		e - American k, White, etc.	Indian,	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				Specify:	,	Specify			
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grea	cation e completed)	16a.	Decedent's Usi	al Occup	etion during most of wor	kina	16b. Kind of Bu	siness/Indust	try	
<u> </u>	/ithin	훁	Elementary/Secondary (0-12)	College (1-4or 5+)				during most of world)	9		olesale		
2	iled v Jygie Ther ti nt, th	ပိ	11 17. Father's Name (First, Middle, Last)			C1e	rk	18. Mother's Nan	no (Eiret Middle		Cloth:	ing	
and	d be f intal h ed of	Be C	Harry E. Nelson								e)		
2	should nd Me mark matic	은	19a. Informant's Name/Relationship (7)	ne Print)	19h	Mailing Addres	s (Street	KOSe and Number or Ru	Dillma		State Zin Co	de)	
S	ulthar Ilthar 27 is r treu	1 1	William F. Alliso										
ē,	s 1 au f Hea ftern (		20a. Method of Disposition	•	20b. Place of	f Disposition (Na ry, cremetory or	me of	Blvd., A	Date	20c. Location	City or Town,	1. 21234 State	
Ë	Pege ento nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			ew Crem			0/23/20	07 Balt-	imoro	Maryland	
<u>=</u>	mit. partm porta y inju		21. Signature of Funeral Service Licens		)	22. Name a	nd Addre	ss of Fecility Sch	nimunek	Funeral	Home	Inc.	
m	Depa Impo		Harama	RIME	Res	9705 B	elai:	r Rd., No	ttingha	m, Maryl	land 2	1236	
			23a. Part1. Enter the disease, or compleshock or heart failure. List only of	ications thet caused the	e death. Do	not enter the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,	Ap	proxi <i>m</i> ate erval Between	
1	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.								Ör	set end Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. E	nd	Stace	0	emention	4.		1		
		<u>.</u>	resulting in dealth)			consequence of)	:		•				
8.	uted 1 Insit	Examiner	•	). ————————————————————————————————————									
<u>,</u>	execu	Exa	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Di	ie to (or as a c	onsequence of)							
68760,	te be ysicia ne bur	edlcai	Cause (Disease or injury that initiated events	)	e to (or as a c	consequence of):							
30	eath certificete be executed attending physician end I for use es the burial-transit	Med	resulting in death) Last										
X Q Q	ath ce ttendi or use										-		
- -	the a	Physician/	Part II. Other significant conditions cor	tributing to death but i	not resulting in	the underlying	cause giv	en in Part i.	23b. Did	tobacco use cor	tribute to the	cause of death?	
Division of vital Records, P.O.	v requires that the death or been signed by the attend should be deteched for us	Ph								1 □ Yes 2 □ No 3 □ Probably 4 □ √Unkno			
Sp.	n sign	d by								24a. Wes en autopsy performed?  24b. Were eutopsy find available prior to completion of caus of death?			
ပ္သ	Ine law requires that the death ste has been signed by the atter page 2 should be deteched for u	Completed											
֓֞֞֓֓֓֓֓֓֓֓֓֓֓֟֝֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֡֝֓֓֓֓֡֓֡֝	ine is ite ha	E							101	res 2 🗆 Ko	1 □ Y€	es 2□ No	
<u> </u>	an: I	Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	nne)			
_	nysic his ce il dire	2	1 ☐ Yes 2 ☑ No	lospital: 1   Inpatient	2□ ER/Ou	tpetient 3 D	OA Oth	er: 4 Nursing H	4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)				
ב ב	ing P		27. Marfner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. T		28c. Injun Worl		28d. Describe I	now injury occurr	ed		
SIC	Avending Physician: or death. sector: After this certific by the funeral director,	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Disease file	A4 h a m = fa	M		Yes 2□No	Of Leasties //	Street and Number		outo Atumbar	
5	or A efter Direc	Certification:	4 ☐ Homicide determined	28e. Place of injury building, etc. (	Specify)	rm, street, tactor	у, опісе		City or Tov		er or murai mo	oute Number,	
	to the negating of whending Physicien: The law within 24 hours effer death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Phys	icien: To the best of r	ny knowledge,	, death occurred	at the tin	e, dete end place,	and due to the	ceuse(s) and ma	nner es state	d.	
	in 24 the Ft	ledical	one)	er: On the basis of ex and manner state	emination end								
i	Son Too	Σ	29b. Signature and title of certifier	2-MD		29	c. License	e number		29d. Date signed	(Month, Day	, Year)	
			100				116	1785		10/	22/0	7	
	5		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (	Type, Print)	ıΩ	lad, Pa	and all	Min -	//		
		20	31. Date filed (Month, Day, Yeer)	32 Registrar's	Signature	waith	10	wa pa	whille	FW L	1134		
	Sta Registr		OCT 2.6.20	17 Segral	1	Course )	7	,					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician 4:15 A M October 2007 Johanna Alexander 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 K F Months Hours Yrs 82 Oklahoma Director 441-22-7957 July 20, 1925 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortant: If them 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 21 No Director Prince George's Laurel 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 12703 Silverbirch Lane Funeral 20708 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ACTNo þ Specify: White **¾**CXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen G.T. Vaughn Marie Sleif ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sykesville, MD 21784 Carol B. Russell/Daughter 7498 Wind Swept Court, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 10/29/2007 Crownsville, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee **M01103** 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 Day **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2XXNo Month Year Day 4□Pregnant at time of death 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Diabetes Mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2★★No 24a. Was an autopsy performed? Yes 2 XNo 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes ¾XNo 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Certification: 2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier Medical

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

29c. License number

D24721

29d. Date signed (Month, Day, Year) October 24, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq, MD Laurel Bowie Road, Laurel, MD 14333

State Registrar

OCT 2 6

31. Date filed (Month, Day, Year)



William Lowell BATTEN 07-08109 **UNK UNK** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 34356 Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month Day October 17, 2007 Medical Examiner 2224 hrs William Lowe11 Batten 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 181 Northbound @ Exit 10 Hagerstown Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs Foreign Months Davs Hours Min Director Country) 229-78-8228 1955 1 X M 2 F 52 26. Usual Residence of Decedent in, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medienl Examiner must be notified at once. Augusta Fort Defiance Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1697 Knightly Mill USA Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married 1 Never Married 2 X No Yes If Yes, Give Year Divorced Widowed Yes 2 X No specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lawrence Batten Patricia Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>P</u> Carol Jean Batten/Wife 1697 Knightly Mill Rd., Fort Defiance, VA 24437 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place)
Eastlawn Memorial
Gardens 1 X Burial 2 Cremation 3 Removal from State 10 - 26 - 07Donation 5 Other Specify Harrisonburg, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson Funeral Service, Inc. Grottoes, VA 24441 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed Physician/Medical physician a UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o þ 1 Yes 2 V No 3 Probably 4 Unknown The law requires Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Other; ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient this 1 🗸 Yes After 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Oct 17, 2007 Driver of tractor trailer involed in collision Division Natural 2122 hrs 1 ✔ Yes 2 Pending within 24 hours after death Director: the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) I81 Northbound, Hagerstown, MD (Specify) Interstate To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 18, 2007 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 3 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

DOME

Physician
/Medical
Examiner

Funeral Director

Department of Health and Mental Hygiene Instural; or Iteme 23a or 28a-f show Important: If Item 27 is marked other then "natural; or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Madical Examinar must be notified at once. Once.

Baltimore, Maryland 21215-0036

MARY BUCKLE

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Turthe Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transli

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of Maryland /	-	ificate of L			eg. No.	34351			
ın	Decedent's Name (First, Middle, Last)     Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	3. Time of Death			
al	Mary K. Buckle  4a. Facility Name (If not institution, give stre	eat and number		4b. City, Towns or	ocation of Death	OCTUBER	2 24 200 4c. County of Dea				
er	LORIEN (D) RIVI	ORSIDQ		Bei	CAMO	AARGO	ed				
	5. Social Security Number 6. Sex 1□ N	7. Age (In yrs. last 84	birthday)_ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 2	9. Bir 7,1923 CO	thplace (State or Foreign ountry) Lorado			
	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits			
ŏ	Maryland Harford Belcamp										
rect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co										
Be Completed by Funeral Director	1123 Belcamp Road	l		21017		τ	United States	5			
	11. Marital Status 12  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XX o ff Yes, Give Year or Dates:	lf '	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🛣 No Specify:			14. Race - Am Bfack, Whi	te, etc.			
edb	15. Decedent's Educa	tion 1	6a. Decede	ent's Usual Occupa	tion		16b. Kind of Business				
plet	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. D	ind of work done d O NOT use retired)	uring most of wor	_					
Con	12	N/A	Home	Maker			Own Home				
To Be	17. Father's Name (First, Middle, Last) Peter Georgoff				Marie Fra	ne (First, Middle, i US	Maiden Sumame)	Sumame)			
	19a. Informant's Name/Relationship (Type Mrs. Linda Jungkm						r, City or Town, State, Maryland				
	20a. Method of Disposition  1 № Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	etery, cremi	ition (Name of atory or other place Memorial			20c. Location - City o				
	21. Signature of Funeral Service Licensee	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	22.	Name and Addres	s of Facility	V2	on Services - Maryland 2105				
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the of sease, or complica shock, or heart failure. List only one Immediate Cause (Finaf disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	1 + 12 ce of):	fita	t Fai	Tur		Interval Between Onset and Death  V.F. C.Y.			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	lelivery Day Year									
	Part ff. Other significant conditions control		to the cause of death?  Probably 4 □Unknown								
	And Amlatin Annia  24a. Was an autopsy performed?  1 Yes 2 No 1 Yes										
Be (	25. Was case referred to medical examiner?	-siteli		104		ath (Check only or	ne)				
tion: To	1 Yes 2 No  27. Manner of Death  1 Nonatural 5 Pending 2 Nocident investigation		Date of Injury 28b. Time of 28c. Injury at				ence 6 □Other (Sp ow injury occurred				
Certifica	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Recoil of the building, etc.)										
dicai (	2.a. Cartifur (Check only one)  2.a. Cartifur (Check only one)    Cartiful Physician: To the basis of in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier	Man un		29c. License	number 7 9 7 <b>5</b>	i	29d. Date signed (Mor	onth, Day, Year)			
	30. Name and address of person who com	ppleted cause of death (Item 23		Print)	noi Mha	Ind	AU AW	10021014			

State Registrar

31. Date fifed (Month, Day, Year) OCT 2 6 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Vear **Physician BYTHEMA** BRADFORD 6:15 pm<sup>M</sup> October 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LONG GREEN CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Yrs Director 218-28-9842 Usual Residence of Decedent APR 10 1933 MARYLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at NXYes 2 □ No Directo MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or Items 23a or 1024 STODDARD CT Funeral 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 200No Specify: BLACK þ 3 Widowed 4 XDivorced Completed event, the Medical Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th grade HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ ULYSSES SIMPSON BELLAMY RUBY PENIX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is 1627 N. Gilmore St., Baltimore, Maryland 21217 Glenda Bradford/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 10-22-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22 Name and Address of Eaching COMMUNITY FUNERAL HOME P.A. ▶ 1206 W. NORTH AVENUE implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. Frint1. Enter the disease, or shock, or heart failure. List I mediate Cause (Final disease or condition resulting in death) **Physician** (VICO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, consequence of). if any, reading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hnemic physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, P Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Por Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1) ement 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1□ Yes 2☑No 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 TYes ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manna of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 - Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and (itle of certifier D0064788 22 10 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MI. ROTAL AVE BALTIMORE havma 1600 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State OCT 2 6 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 5:40 P AGNES COHEE OCTOBER. 20, 2007 BOWMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 208 Kennard Ave. Harford Edgewood If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Yrs. 89 9, 1918 Maryland Director 215-32-8280 Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or iteme 23a or 28e-f show any hjury or other traumatic event, the Madical Example and mail be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 208 Kennard Avenue 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supply Clerk U.S. Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Rutter Cohee Agnes Mary Carnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 210 Kennard Ave., Edgewood, MD 21040 John C. Bowman III / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 10-26-07 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Six ature of Funeral S McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 MOU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo carelial.

Due to (or as a consequence of): **Physician** infarction /Medical Examiner stage renal disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 attending physicien by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after deeth.

To the Funeral Director; All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. \*\*Conflying Physician: To the best of my knowledge, Jean occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 22, 2007

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie Linder 902 Averill Rd Joppa, MD 21085

Linder

Sternance.

31. Date filed (Month, Day, Year) 001 2 6 200

Stephanie

\_ MO

32. Registrar's Signature

A State of

10043909

State of Maryland / Department of Health and Mental Hygiene 34360 Reg. No 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19, 6:57 P M October 2007 John E. H. Bailey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Months 1 ☑ M 2 ☐ F 86 Feb 28, Director 217-03-2489 1921 Mary Land Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10h. County Department of Health and Mental Hygiene, indural, or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Director MD Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 Towsontown Court #211 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural"; or Ite 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: white ò 3 ₩ Widowed 4 Divorced 42-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) un. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1aw 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Hamilton Perry Ould Bailey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 230 Tyrone Circle Baltimore, MD Susan B. Muller/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) permit. 21. Signature of Fune al Service License Rohald S. Wile, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com-shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final alstress syndrom **Physician** taays res disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fr as a consequence of) Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 □Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 CIDama Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital? 1 Yes Certification: To 2 ER/Outpatient 3□ DOA Unpatient After this Manner of eath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D0030717 \$ 30. Name and address of person who completed cause of suath (Item 23a) (Type, Print) Charles St Suite 5201 0 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 6 OCT Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** CHAG-OUZIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE VA MADIKAL CONTEX Date of Birth (Month, Day, Year) 11/7/1924 Birthplace (State or Foreign Country) **Funeral** 219-16-6453 Director Balt., Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 √Yes 2 No 28a-f sh notified Director Baltimore Maryland Baltimore 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 600 Light Street Apt. #508 21230 America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Never Married 2 Married to Yes 2 □ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2011No à Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) 12 College (1-4or 5+) self employed vending permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important; If Item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Chagouris Stella Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgianna Atzrodt/ niece 6819 Arthur Hills Drive Williamsburg, VA 23188 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Vielnorial Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) 26, 2007 Timonium, Maryland 21. Signature of Juneral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SHOCK Physician SEPTIC /Medical Examiner CELLUCITI Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. I been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an After this certificate had funeral director, page perform or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Mpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

16 Ni GRONE STREET

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death october 23.2007 7:25 P M **Physician** Arthur M. Cayce, Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day Year)

July 24, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1X M 2□ F Maryland 216-20-2469 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No MD Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 9605 Alda Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life, DO NOT use retired)

Fireman Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Fire Department 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara E. Mixter Arthur Milton Cayce, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9605 Alda Drive-Parkville, Maryland 21234 Betty Cayce-spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.27,2007 Timonium, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 8800 Harford Road Parkville,MD 21234 21. Signature of Funeral Service Licensee andrae Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cars Physician /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 s certificate has autopsy perform 3 2 No egener Division or Vital To the Hospital or Attending Physician: director, as case r f rred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 25,01Ce Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified , wo address of person who completed cause of death (I em 3a) (Type, Print) N. Charles St. Balto Md Ze 20x SBM 70 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 26 Registrar 2007

			For State Registrar	State of M	arylan		artment of H rtificate of I		ental Hyرا آ	giene Reg. N20	07	34363	
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	/Medio		4a. Facility Name (If not institutio			Jarmirc		Location of Death	1		y of Death	7:00 A	
	Examir	ier	9306 Montpelie				Laurel					eorge's	
_~~	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birtho	lace (State or Foreign	
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	p ,	1	Usual Residence of Decedent		I 100 Cib	, Town or Lo	cation				1.		
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Maryland	I 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. I sameked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle,				j	18. Mother's Nam		Maiden Surna	me)		
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	Physician	7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Coronary Artery Disease										
	/Medical		disease or condition resulting in death)  Coronary Artery Disease  Due to (or as a consequence of):										
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Sign	Attending r death. ector: After by the fune	cati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	iuny . At ho	me form etr	M 1 ☐ 1	Yes 2 □ No	296 Location (C	through one of the second		I Don't Mineton	
Division	- 9	Certification:	4 ☐ Homicide determ		tc. (Specify		eet, factory, office		City or Tow	n, State)	Dei Oi Huia	al Route Number,	
_	splta ours neral / fillec		29a. Certifier 1 X Certifyi	ng Physician: To the best	of my know	wledge, deat	h occurred at the tin	ne, date and place	, and due to the	ause(s) and m	nanner as s	tated.	
	To the Hospital of within 24 hours aff To the Funeral D completely filled in	Medical	(Check only 2 ☐ <b>Medical</b> one)	Examiner: On the basis of and manner st	of examinat ated.	tion and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place	, and due to	o the cause(s)	
	To the within To the Comp	ž	29b. Signature and title of certifie	er A	11.50	)	29c. License	number		29d. Date sign	ed (Month,	Day, Year)	
	A		Mur G	Im	WH)		D249	997		Oct 23,	2007	,	
	Y		30. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)						
	1		Luis A. Casas,				e, Laurel	, MD 2070	7				
	Sta		31. Date filed (Month, Day, Year)	fet .	rar's Signat	ture	A.						
	Registr	ar	OCT 2 6	LUU! Killing	1 13								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2007 34364 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 7:50 AM John (nmn) Cromwell Sr. October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death Harford Citizens Grace NUVSINO Home HOIVVE de 8. Date of Birth (Month, Day, Year) Sep. 20, 19 5. Social Security Number If Under 1 Year | If Under 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) Days Hours 1 XM 2 ☐ F 1925 82 156-16-3064 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Abingdon 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 Apt. A Forsythia Ct. 21009 USA 4. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer 12 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew (unk) Cromwell Marion (unk) McAllister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Sue Cromwell / Wife 303 Apt. A Forsythia Ct., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 10-25-07 Owings Mills, Maryland 21. Six happy of Funeral Service Live See McComas Afresse Fair Home, P.A. 23a. Parti. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) avtery Cormary Due to (or as a consequence of): Diabetus mellin Sequentially list conditions. Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Dementia Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 🗓 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 26. Place of Death (Check only one) 2[ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

sician and burial-transit certificate be executed YOMWell 시에 M Division o'r Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria peen has this certificate filled in by the funeral director, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Physician

/Medical

Examiner

Directo

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Completed

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Exami

**Funeral** 

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If Item 27 is marked other i any Injury or other traumatic event, <u>II</u>

**Physician** 

/Medical

Examiner

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 25. Was case referred to medical Be 1 ☐ Yøs 2 27. Man er of Death Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

D46412

State

Registrar

(Mohth, Day, Year) 6 2007

29b. Signature and title of certifler

M.D

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

10/22

State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 34365 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician RYUKO IWANAGA COOK 2007 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1808 HOWARD MANOR COURT GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 XF 212-84-3325 82 8/10/1925 Director JAPAN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD ANNE ARUNDEL 1 ☐ Yes 2 No Director GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 HOWARD MANOR COURT 21060 JAPAN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Ealtimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN Specify: à 3 ☐ Widowed 4 K Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. 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Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN ပ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a MR. MORGAN J. COOK - SON 1808 HOWARD MANOR COURT, GLEN BURNIE, MD 21060 Di partmen of Health in portant: if item 27 any injury or other troor e. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION: 10/29/2007 STEVENSVILLE, MD 21. Signatu 22. Name and Address of Facility SINGLETON FUNERAL AND CREMATION 1 2ND AVE. S.W., GLEN BURNIE, MD 21061 mo1120 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physiclan** Month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 TYes 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fund completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2. To the I the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) Actober 25, 2007 ay M.D D39505 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dv. Glen Surve, MD. 21061 305 Markan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-07809 Edward J. Collins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

ward J. Collin		1-For State of Maryland / Department of Health a	and Mental Hygiene	2007 3430								
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2 ~			me, date and place, and due to pinion, death occurred at the tir	the cause(s) and manner as stated.  me, date and place, and due to the cause(s)								
To the Ho within 24. To the Fu	Medical	and manner stated.  29b. Signature and title of certifier  29c. 1	License number	29d. Date signed (Month, Day, Year)								
	2		O.C.M.E.	October 7, 2007								
		30. Name and address of person who completed cause of death (Item 23a)										
(H)		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 2120	01								
	State											
Regi	stra	OCT 2 6 2007 Reserved St. Appendix										

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2007 **Physician** Oct. 24, Pauline Roberta Drawbaugh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3344 Kensington Square Carroll Manchester if Under 1 Year | if Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2√XF 84 July 13, 1923 Director 216-16-1962 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. 10c. City, Town or Location 10b. County r 28a-f show notified at Director Maryland Carroll Manchester 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be r 3344 Kensington Square 21102 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White þ XX Widowed 4 ☐ Divorced d other than "natural", event, the Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Office Manager Insurance 7 Is marked other traumatic event. the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joshua Boslev Nellie Peltzer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troone. Donna M. Williams (Daughter) 241 Knoxlyn-Orrtanna Road, Gettysburg, PA 17335 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 25, 20a. Method of Disposition 20c. Location - City or Town, State Oct. 1 ☐ Burial 2XXX rem 3 Removal from State 4 □Donation 5 □ other Specify) Metro Crematory 2007 Catonsville, Maryland 21. Signature of Funeral Pervise License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** 1000 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and sthe burial-trans Due to (or as accesseduence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 ☐Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 24a. Was an page 2 autopsy performe certificate Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. ဥ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Jepital o, 4 hours after dea, real Director: A in by the 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/8 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or to and manner stated. urred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check only estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2:40 P. M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1XXYes 2□No

Maryland

Registra DHMH 17 Rev 1/2001

State

0016

(Type, Print)

death (item 23a

2. Registrar's Signature

30. Name and address of person who completed cause of

Blever 31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 23, 2007 Mary Margaret DiBlasi 11:45 a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Hospital n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 217-18-8100 Maryland 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 East Fort Avenue 21230 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother Home Maker 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Fold Margaret Ε. Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. DiBlasi Jr. (Son) 415 East Fort Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Cedar Hill Cemetery 10-25-07 Brooklyn Park, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. m 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of Sequentially list conditions, if any: leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1∐ Yes 2 No 2 00 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KR/Outpatient 3 DOA 1 Tes 2 No 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

3

Completed

Be

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, the Medical Examiner must he market to once.

altimore, Maryland 21215-0036

Examine and burial-trar physician Physician/Medical the attending properties for use as ed by the a signed to 2 Completed cate has t page 2 s certificate funeral director, Be Certification: To this After t To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. filled in by

Division or Vital Records, P.O. Box 68760,

**Sompletely** 

Medical

State Registrar

29c. License number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

St.

6 Could not be determined

MD, FACP

57088

1 ☐ Yes 2 ☐ No

OCTOBER 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tant

Bentimor

21202

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a, Certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene For State Registrar Amend 20a-c., perFH, g872, 10.26.07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year /Medical <u>Luis DeLuna</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1₩ M 2□F Director 466-30-7796 79 Oct. 16, 1927 Texas Usual Residence of Decedent 10a. State 10h. County 10c, City, Town or Location 10d. Inside City Limits ed other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ➡ No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Joppa Farm Rd. 21085 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 17 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1XX Yes 2 □ No Specify: Completed by Specify: iled within 72 hours 3 Widowed 4 Divorced Year or Dates: Mexican White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Mail Carrier</u> U.S. Postal Service Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ment of Health and Mental Luis (NMN) DeLuna ٩ Injury or other traumatic Maria L. Palacios 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health an Geraldine A. Martinez-DeLuna/Wife 722 Joppa Farm Rd., Joppa, MD 21085 Baltimore. 20b. Place of Disposition (Name of procedure) 20a. Method of Disposition Date\_LTC 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Ξ Arlington, Virginia Arlington National Cemetery 12-5-07 21. Signature McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or complications shock, or heart failure. List only one cays Immediate Cause (Final disease or condition resulting in death) AD **Physician** /Medical Due to (or as a consequence of): Examiner PREUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ASCVD To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ₩6 24a. Was an page this certificate perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No P Inpatient 2 ER/Outpatient 3□ DOA 27. Man of Death After t Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Worldham Woods food, Suit 204, m D 21234 2813 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State 26 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day DeRosa Vincent CTOBER 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A MOSPITAL TIMOR If Under 24 Hrs. GNES 8. Date of Birth (Month, Day, Year Oct. 16, 1 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days Hours Months 1⊠M 2□F 212-52-8737 53 1954 Maryland Oct. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 TYes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Punjab Drive 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1⊠Yes 2□No IfYes,Give Year or Date**P.eacetime** 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 € Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Wire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert DeRosa Natalie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. DeRosa (Brother) 1183 Punjab Drive, Baltimore, MD 21221 20b. Place of Disposition (Name of Baffereles) ciematory of the color Park (Loudon Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/22/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EALTH PNEUMONIA CAL Due to (or as a consequence of) one west Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

burial-trar Records, P.O. Box 68760, the attending p for use as the signed by t page 2 should Division or Vital

Physician/Medical Completed this certificate has After t Hospital or Attending n 24 hours after death.

ne Funeral Director: A
bletely filled in by the fu

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

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Certification:

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

VENKATA

**Funeral** 

Director

show

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other transmitted.

Physician

/Medical

Examiner

within 72 hours after death

Baltimore, Maryland 21215-0036

the ပ

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

6 Could not be determined

KOYYA

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

900 ATON

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Cary Engerman 2:40 AM 200' /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Southwar 6. Sex 1 M 2 F 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 3/22/1946 Birthplace (State or Foreign Country) **Funeral** Months 531-44-0021 Days Hours Min. 61 Director Washington Usual Residence of Decedent with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 314 Southway 21218 Funeral America
Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Electrical Engineer Northrop Grumman 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Grace T. Ashley Jack J. Engerman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Curran/ wife 314 Southway Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans funeral
Chapel Bellair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Sign Peaceful Alternatives Funeral & Cremation Ctr., P.A of uneral Service Licens 2325 York Road Timonium, Maryland 21093 23a. Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nemon Y mon /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: ို 1 ☐ Yes 2 🔽 No 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify) 27. Manner of D 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation in 24 hours and the Funeral Director; Af 2 Accident 1 ☐ Yes 2 □ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

OCT 2 6 2007

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FEEE. a.M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 October 10:55 AM Ebersberger Μ Anna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brightview Senior Living Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F Days Hours Min. 93 Jan, 13, Maryland Director 213-82-5342 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No **Funeral Director** Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 716 Maiden Choice Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Thomas Horst Katherine Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau Son <u>John M. Ebersberger, Jr.</u> <u>67 Wood Duck Drive</u> Ocean Pines, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 KX remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 10-26-2007 Towson Maryland 21. Signature of Funeral Sec 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCHERO TIC **Physician** /Medical Due to (or as a consequence of): Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 22 0 1 ☐ Yes 3 Probably 4 ☐Unknown **Director:** After this certificate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 → No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 1 ☐ Yes 30 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,



2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMITH

SUITE 253

Division or Vital Records, P.O. Box 68760

	•	For State Registrar		,	Cert	tificate of I	Death		Reg. No.	2007	343/4
Physicia	an	1. Decedent's Name (First, Middle, Las	•					2. Date of D Month			3. Time of Death
/Medic		Sophi						Octob		3, 2007	8:15 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, give				*	Location of Death		4c.	County of Deat	
(3)×		10101 Grosvenor I		(In yrs. last i	hirthday)	Roc	kville If Under 24 Hrs.	8. Date of B	irth	Montgo	mery thplace (State or Foreign
Funeral Director		002-38-1098	M 2 1 F	97	Yrs.	Months Days	Hours Min.	March	ay, Year) 17 <b>,</b> 1	910 Gr	ceece
land t	ŀ	Usual Residence of Decedent  10a. State 10b. County	1.	10c. City, To	wn or Loc	ation					10d. Inside City Limits
Mary -f sho	ō	Maryland Montgom	erv	Roc	kvil1	e					1 □Yes 2 No
r 28a	Director	10e. Street and Number		- 1100		10f. Zip Code			10g. Cit	izen of What Co	ountry?
th with		10101 Grosvenor	Place, #207			2085	52		Uni	ted Sta	tes
ems erm	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecity Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit	
	۾	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	)		□Yes 2MNo					Thite
72 ho	etec	15. Decedent's Ed (Specify only highest gra		16	Sa. Decede (Give k	ent's Usual Occup	ation during most of world)	king	16b. K	ind of Business/	/Industry
within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)	_		d)		110	ir Salo	_
filled v Hygie ther int, th		17. Father's Name (First, Middle, Last)			Own	ler_	18. Mother's Nam	e (First, Middl			11
ld be ental ked o	To Be	Theodore Harissa	5				Virgin	ia Not	Ava	ilable	
shou ind M imar	۲	19a. Informant's Name/Relationship (		1	9b. Mailing	Address (Street	and Number or Ru				Zip Code)
und 2 alth a 27 is		Aliki Maragos /	Daughter	8	615 H	lempstead	l Avenue,	Bethes	sda,	Marylan	d 20817
les 1 a of He of He if Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other plac	) Nove	Date mber	20c. Lo	ocation - City or	Town, State
t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (Specif	()	Mt. A		n Cemete	, ,		1		ssachusetts
permi Depar Impo any ir		21. Signature) of Funeral Service Licer	9/	01305	Rob 755	pert A. Pun 7 Wisconsi	in Avenue,	ral Home Bethesda	/Bethe	esda-Chev 1and 208	y Chase, Inc. 14–3501
		23a. Part1. Enter the disease, or com shock or heart failure. List only		Approximate Interval Between Onset and Death							
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/Medical Examiner		resulting in death)	Due to (or as a								
* *	e.	Sequentially list conditions, if any, leading to immediate	b. End ome			er					
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			·						
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The law requires that the death or attending the attending 2 should be detached for use	Physician/	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	9☐ Unknown	mo or dodar		- (apouny) _					
s that	by Pl	Part II. Other significant conditions	ontributing to death but	not resulting	g in the und	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
equire en sig ould b								1 [	Yes 2	No 3□P	robably 4 ☐Unknown
e law re has ber je 2 sho	Completed							24a. Wa	s an opsy	24b. Were au	utopsy findings available completion of cause of
The ate h	Som							per	formed? 2 X No	death?	
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Physi this a	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient		Outpatient o. Time of	3 DOA Oth	4 Linursing H	ome 5 X Res		6 □Other (Spe	ecify)
nding ath. r: After re funer	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injur Wor M 1 □	yes k? Yes 2 □ No	Zod. Describe	7 now inju	ry occurred	
or Atte fler dea Directo in by th	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.	y - At home, (Specify)	farm, stre	et, factory, office			(Street ar own, State		ural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page			ysician: To the best of								
the Hin 24 the Ft	one) and manner stated.										
with Con	2	29b. Signature and title of certifier									
		1 Jan			\	D004	7612		Octo	ober 24	, 2007
15		30. Name and address of person who Paul L. MacKoul,					#414, B	ethesda	, Ma	ryland	20814
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar			ne .					
Registra	ar	OCT 2 6 2	711/	had allo	stato.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s					

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			For State	State of Maryla		artment of H rtificate of L				01075
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京	Physic /Medi		Gladys L	-orraine	Fos	ler		OCTOBER	Day Year 23, 200	7 2:00P M
	Exami	ner	4a. Facility Name (If not institution, giv Saint Joseph	e street and number) Medical Ce	nter	4b. City, Town, or	Location of Death		4c. County of Deat	timore
34	Funeral Director		219-40-7000	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt Co 10 1m	hplace (State or Foreign buntry)
	yland row at		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	e Mar la-f sh tified	ctor	MD Balti	more	Park	ville.				1 ☐ Yes 2 ☑ No
	vith th	Director	10e. Street and Number	Pood		10f. Zip Code	1	10g.	Citizen of What Co	untry?
	leath v	Funeral	2522 East &	ppa Road  12. Was Decedent Ever in	U.S. 13 V	Vas Decedent of His	Spanic Origin? (Spa	cify Ves or No.	14. Race - Ame	rican Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I □ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	
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Mar	d2sh thand t7 ism traum		19a. Informant's Name/Relationship (	ype. Print)	19b. Mailin	g Address (Street a	and Number or Rura	Route Number, Ci	ty or Town, State, Z	Zip Code)
	es 1 and 2 of Health fitem 27 i		Konald Walker  20a. Method of Disposition	- 30n	Place of Dispo	sition (Name of natory or other place	Joppa Kg		Location - City or	Town, State
imo	Pag nent ant: i		1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		lar Hill	Cemeters Cemeters	1 .		en Burnie	,
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licenta Calc.	Martin	£22		of Facility	1 + Cremat	non Service	es-Parkuille
F			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lications that caused the dea	ath. Do not ente	er the mode of dying	g, such as cardiac o	respiratory arrest,		Approximate Interval Between
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68760,	ificate be executed g physician and as the burial-transit			Due to (or as a conse	equence or).					
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ta	an: Th tificate or, pag		25. Was case referred to medical					performed 1□ Yes 2		2□ No
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Division or	ing PI		27. Manner of Death  1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work?		3d. Describe how in		
isic	Attend death ctor: / y the f	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At h	nome farm stre		es 2□No	of Location (Camera		18
<u>S</u>	al or A	Certification:	4 ☐ Homicide determined	building, etc. (Speci	ify)	ot, factory, office	20	City or Town, St	and Number or Ru ate)	rai Houte Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 12 Certifying Phyone) 2 Medical Exam	rsician: To the best of my knoiner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause d at the time, date	(s) and manner as and place, and due	stated. to the cause(s)
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	4		30. Name and address of person who c			,	CHICON	dana ar		
	Sta	te	TIMOTHY LOW M 31. Date filed (Month, Day, Year)	32 Registrar's Sign	-		OWSON,	MARYLANI	21204	+
	Registra	ar	OCT 2 6 201	17 Feet 1	H Ana	2000				

		·	1 - For State Registrar	State	of Mar	yland / Depa <i>Ce</i> a	artment of F rtificate of			giene Reg. No.	007 3	34376
Н	Physici	an	Decedent's Name (First, M.	ddle, Last)					2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	/Media			M. Fitch					Octobe:			:45 P M
	Examir	ier	4a. Facility Name (If not institu					r Location of Deat		4c.	County of Death	
			3515 Wilk 5. Social Security Number	ens Avenue	-	In yrs. last birthday)	If Under 1 Year	Baltimore		h	Q Risthola	no (State or Foreign
	Funeral Director		214-01-2551	1 M 2 X F	98		Months Days	Hours Min.		/, Year)	9. Birthpla Country New	ce (State or Foreign y) W York
	pus M		Usuel Residence of Decedent  10a. State 10b. Cou		1	0c. City, Town or Lo	ecation				100	d. Inside City Limits
	Aaryle f sho	ō				oo. ony, rown or co					100	1X Yes 2 □ No
	28a-	Director	Maryland  10e, Street and Number	N/A			Balt:	imore		10a. Citiz	zen of What Countr	v?
	3a or	Ö	3515 Wilkens	Avanue				21229		-	. S. A.	, .
	deati	Funeral	11. Marital Status	12. Was De	cedent Eve	er in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-		14. Race - American	
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or tiems 23a or 28a-f show important: If tem 27 is marked other than "natural", or tiems 23a or 28a-f show any highly or other traumatic event, the Marical Examinar must be notified at ance.	þ	1 ☐ Never Married 2 ☐ M	Married 1 ☐ Yes	Forces? s 2 X No Give Dates:		f Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	to Rican, etc.)		Black, White, et Specify: Whit	
2-0	72 ho	Completed	15. Dece	dent's Education	<del>-1</del> )	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kir	nd of Business/Indu	istry
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Maryland	2 should be and Mental Is marked of raumatic ever	2	Anthony Gal  19a. Informant's Name/Relation			19b. Mailir	ng Address (Street		ce Barace		Town, State, Zip C	(ode)
	and 2 sealth ar n 27 is		Elaine Farlow		)						Maryland	
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Ë	Pages nent of I int: If It		1 🔀 Burial 2 □ Crematio `4 □ Donation 5 □ Other		n State	Gardens o		· 1	7/2007	Balt	imore, Ma	aryland
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other transitions.		21. Signature of Funeral Serv	ice Licensee	•	22	. Name and Addres				ral Home	
<u> </u>	40 F # 9		Buch	a. W.	ell						Maryland	21236
A	Physician be executed // Medical Examiner so the purial-transit	edicai Examiner	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a c		stive ry ar	1	disé	1 (	re	Onsel and Death 4 years
	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 [gnant at time	Fetal death 3	Ectopic pregnancy			2	3d. Date of delivery Month D	y Year
rds, P	w requires that been signed t should be deta	þ	Part II. Other significant cond	litions contributing to	death but n	not resulting in the u	nderlying cause give	en in Part I.			se contribute to the	
		Completed							24a. Was a autop: perfor	sy	24b. Were autops prior to comp death?	sy findings available pletion of cause of
/ita	nyaician: Th nis certiticate director, pag	Be (	25. Was case referred to med examiner?						ath (Check only or	10)		
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n c	tending Ph Jeath. tor: Atter thi the funeral	lon	27. Manner of Death 1 ☑Natural 5 ☐ Per	ding (Mo	e of Injury onth, Day Y	ear) 28b. Time of Injury	28c. Injun Work		28d. Describe h	ow injury	coccurred	
<u>s</u>	or Attending Physician: after death. Director: Atter this certific in by the funeral director,	cat	3 Suicide 6 □ Cou	stigation ild not be	ce of Injury	- At home, farm, str		Yes 2 □ No	28f Location (S	treet and	d Number or Rural F	Poute Number
<u>&gt;</u>	s after s after al Dire	Certification:	4 Homicide	emined 200. Place	ding, etc. (	Specify)	eet, ractory, office		City or Tow			TODIO TAGINDOT.
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifier (Check only one) 1 Medic	ying Physician: To the and ma	ne best of m basis of ex inner stated	amination and/or inv	occurred at the time restigation, in my of	ne, date and place pinion, death occu	, and due to the c irred at the time, d	ause(s) late and	and manner as stat place, and due to the	ed. he cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of cert	ifier			29c. License	number	2	29d. Date	e signed (Month, De	ey, Year)
			Iha	uas fr	nu	cure	DZ-4	-334		Oc.	+ 25,	2007
	2		30. Name and address of pers	on who completed cau	use of deat	h (Item 23a) (Type,	•					
			Thomas Finuca 31. Date filed (Month, Day, Ye		Hopk:		ew, 4940	Eastern	AVe., Ba	ltin	nore, Md.	21224
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician OCTOBER 23 RUTH FELDMAN 2007 11:36P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 X F Months Days Hours 0370771909 216-48-1330 98 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 GREENSPRING AVENUE 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Specify Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMON **EMANUEL ISAACS** Н MARTHA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHALL FELDMAN / SON CLEAR SKYS COURT, APT. #T2, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 10/25/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of Facility 21. Signature SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) a∐tJnknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 2. No 3 Probably 4 Unknown 1∏Yes Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No P 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Matural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a N CHARLES ST 8UITE 209 DOBERMAN MD 0505 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 2 Registrar

cian	1. Decedent's Name (F Ruby	First, Middle, Last)			Glover	2. Date of De Month	20 2007	3. Time of 1.			
dical niner	4a. Facility Name (If no	nt institution, give s	street and number)		4b. City, Town, or Location of Dea		4c. County of De				
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al or	5. Social Security Num 215-24-75 Usual Residence of De	21		77 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Da	9. Bi 9, Year) 06 29	irthplace (State or Country) MD			
Director	MD 10a. State	Db. County NA		10c. City, Town or I	Limore			10d. Inside City			
	10e. Street and Number				10f. Zip Code		10g. Citizen of What C	•			
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	12th grad		4yrs	<u> </u>	Human Resources		Johns Ho Maiden Surname)	pkins			
o Be	William J					dwards	maideir Surname)				
Ě	19a. Informant's Name		pe. Print)	19b. Mai	lling Address (Street and Number or Fi		er, City or Town, State,	Zip Code)			
	Carla Glo	ver-Log	gan-Daugl	hter 662	20 English Oaks	Road,	Apt D, PM	arkyill			
	20a. Method of Disposi		emoval from State	20b. Place of Disp cemetery, cr	position (Name of rematory or other place)	Date	20c. Location - City o	r Town, State			
	4 □ Donation 5	Other (Specify)			Crematory Inc 1	0/27/07	Baltimo	re, Md			
ej Ouc	21 Signature of Funer	A A A A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION OF THE A CONSTRUCTION O	"DAIMA	N	22.Name and Address of Facility 1arch F/H West 1300 Wabash Ave	. Balti	more. Md	21215			
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			For State Registrar	te of Maryland	l / Depa <i>Cer</i>	artment of tificate o	Health a	and Mo		iene g. No. 20	07	340	380
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Deat	h Day	Year	3. Time of D	)eath
	/Medic Examin		Michael D. Gray  4a. Facility Name (If not institution, give street a)  FENINSULA REGIONAL MARCHETTE PROPERTY.	nd number) Tedical Ce	nter	4b. City, Town	or Location of	of Death	October	4c. County 6			
	Funeral Director		5. Social Security Number 0 6. Sex 216-44-2261	7. Age (In yrs. la		If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, Oct 24,	Year) 44	9. Birthp Coun Wash:	lace (State or latry) ington	Foreign DC
	Maryland -f show fied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Wicomico	10c. City,	Town or Lo						1	0d. Inside City 1 ☐ Yes 2	
$\Gamma$	with the a or 28a be noti	Director	10e. Street and Number 31972 Buckhaven Court			10f. Zip Code	2180	٦/،	1	0g. Citizen of W	/hat Coun	try?	
36 36 36	be filed within 72 hours after death with the Maryland ntal Hygiene. sc other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 1 □ If Ye	s Decedent Ever in U.S ed Forces? Yes 2 [X] No as, Give r or Dates:		Was Decedent of Yes, specify C	f Hispanic Ori uban, Mexical	igin? (Spec n, Puerto F	cify Yes or No- lican, etc.)	14. Race Black			
Michae d 21215-0	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	12	eted) ege (1-4or 5+) 5+	16a. Deceo (Give life. L	lent's Usual Occ kind of work dor DO NOT use reti	ne during mos ired) ge_prof	essoi	<i>g</i>		catio		
land	should be file nd Mental Hy marked oth Imatic event	To Be (	17. Father's Name (First, Middle, Last)  Thomas Carlyle Gray							Maiden Surnam O'Connor	_		
م/ Mary	and 2 shoi ealth and N n 27 Is ma ier trauma		19a. Informant's Name/Relationship (Type. Print Ruth Gray/spouse	t)						City or Town, S		,	
- ギキ ユュム Baltimore, M	permit. Pages 1 and 2 should b Department of Health and Ment Important: If Item 27 Is marked any injury or other traumatic e once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal  4 ☒ Donation 6 ☐ Other (Specify)	1 00	ace of Dispos	sition (Name of natory or other p	i			20c. Location - (			
əl6-44	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Wards	, Director		Name and Add tate Ana altimore		oard 2120		Baltimo	ore S	treet	
₩ •	Physician /Medical Examiner	ner	Sequentially list conditions b.	that caused the death. e on each line.  Me Las Latic ue to (or as a conseque act o (or as a conseque ue to (or as a conseque ue to (or as a conseque	ence of):			_		est,		Approximate Interval Betwee Onset and De 8 mm HA.	eath 3
Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	an/Medical Examiner	resulting in death) Last  C	ue to (or as a conseque	cy	Ectopic pregna				23d. Date	e of delive	ery	
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	w requires the been signed should be de	ted by F	Part II. Other significant conditions contributing Revial Call Coromety	-	ting in the ur	iderlying cause	given in Part I	,		es 2 12 No			
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	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director A completely filled in by the h	Medical		To the best of my know the basis of examination I manner stated.	ledge, death on and/or inv	estigation, in m	y opinion, dea	nd place, a ath occurre	nd due to the cand at the time, d	ause(s) and mai ate and place, a	nner as st ind due to	ated. the cause(s)	
	Mith Con		29b. Signature and title of certifier	•		Doe	onse number 0/4.3/4			9d. Date signed	7	Day, Year)	
			30. Name and address of person who completed PANPIT P. KLVG. M.L.	cause of death (Item 2	23a) (Type, 1 Cau u	Print) 11 strut	Soli	bu	7. mc	. 21801	ř		
N.	Sta Registr	te ar	30. Name and address of person who completed PANPIT P. KLUG. W. J. 31. Date filed (Month Day, Year) 2007	32 Registrar's Signatu	ire Jan	de							

# Heinlein, Anna 10/aulon

	•	1 - For State Registrar	State	of Maryl		artment of H				giene	1111/	34381
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/Medica Examine	1	Anna Heinlein  4a. Facility Name (If not institution	n, aive street and i	number)		4b. City, Town, or	r Location (	of Death	10-24-		County of Dea	1150 A M
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Director		216-01-3753 Usual Residence of Decedent		8	7				02-28-	1920	Mary	/land
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the M	ecic	Maryland Harf	ord		Forest	H111 10f. Zip Code				10a Cit	izen of What C	1 ☐ Yes 2X No
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is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  itam 27 is marked other than "natural", or Itams 23e or 28e-1 show other traumatic event, the Medical Evanirer must be notified at TO Be Completed by Europe Discosory.	0	Joseph P. Manzo	0					ra J		,	,	
2 sho and N Is ma		19a. Informant's Name/Relations			19b. Mail	ng Address (Street a	and Numbe	er or Rura	I Route Numbe	er, City o	r Town, State,	Zip Code)
C, N 1 and 1 ealth Health am 27 thar tr	-	Robert J. Hein	lein (So		307 b. Place of Disp	Donald Cin	rcle		st Hill		21050 cation - City or	Town State
Pages tment of h tant: If its jury or or		1 X Burial 2 ☐ Cremation  `4 ☐ Donation 5 ☐ Other (S)		n State	cemetery, cre	matory or other place Mem. Park						Maryland
mit. porta y inju	İ	21. Signature of Funeral Service				2. Name and Addres						e of Bel Air
0 89EE9		Buan a	Well	les		nc. 610 W.		Phai	1 Rd Be	el Ai	r, MD	21014
24-14		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause or	each line.				cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. RIG			CANCET	7					
Examiner	Due to (or as a consequence of):  Sequentially list conditions,  b											
executed in and ital-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Under ving Cause (Disease or injury	Due t	o (or as a con:	sequence of):	quence of):						
execul n and ial-trar	1	that initiated events resulting in death) Last	c Due t	o (or as a cons	sequence of):							
ate be executed shysician and the burial-transit			d									
nat the death certificate be by the attending physicis etached for use as the but buystclan/Medical		IF FEMALE:	00- 11			_						
leath certifics attending pl	100	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre birth 2 - F gnant at time o	etal death 3	Ectopic pregnancy Other (specify)				2	23d. Date of de Month	livery Day Year
that the de detached the a	2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unk		5, 65411							
igne ded	2	Part II. Other significant condition HYPERTENS II		death but not	resulting in the u	nderlying cause give	n in Part I.			obacco u Yes 2[		o the cause of death?
The law require cate has been signated a should be completed.		OSTEDPOROS	(5						24a. Was	ап	24b. Were a	utopsy findings available
									autop perfo 1 ☐ Yes	rmed2	death?	completion of cause of
Physician: The This certificate ral director, page To Be Co	2	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only o			
Attending Physician: rr death. ector: Atter this certific by the funeral director,	11.	1 Yes 2 No 27. Manner of Death	11	Inpatient 2 of Injury nth, Day Year	28b. Time o	f 28c. Injury	at		ne 5 🖈 esid 28d. Describe f		Other (Spe	ecify)
auth. or: After ne funer.		1 Natural 5 Pending 2 Accident investig	ation	nth, Day Year	) Injury	Work	? ′es 2 □ t	No				
tal or Attending F rs after death. al Director: After ed in by the funers Certification:		3 Suicide 6 Could r 4 Homicide determi	ned 280. Plac	ce of Injury - A ding, etc. (Spe	t home, farm, str	eet, factory, office		2	28f. Location (S City or Tox			ural Route Number,
Hospital 24 hours a Funaral D tely filled i	-	29a. Certifier 1 Certifyin	Physician: To the	ne hest of my l	knowledge deat	n occurred at the time	e date and	d place a	and due to the	20102(2)	and manner of	a stated
To the Hospital or Attendia within 24 hours after death. To the Hunaral Director: A completely filled in by the transfer in Medical Certification		(Check only 2 ☐ Medical I	xaminer: On the	basis of exam nner stated.	ination and/or in	vestigation, in my op	inion, deat	th occurre	ed at the time,	date and	place, and due	o to the cause(s)
To tha within 2 To tha complet		29b. Signature and title of certifier	1111.0	2 1	A / V.	29c. License		97			signed (Mont	
	-	V V		fant	1 4		150	七十	(		OBFR .	15 2007
5		30. Name and address of person v	who completed call	use of death (I	NORTH		BEL	A	IR I	MD	2 (01	4
State Registrar		31. Date filed (Month, Day, Year) OCT 2 6	2007						<u> </u>		<u></u>	1

			1 - For State Registrar	State of Marylar		artment of F			giene () (	07 3	34382
	Physici		1. Decedent's Name (First, Middle, Last, GRA	ZUTIES				2. Date of Dea Month	Day	Year 20 07	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give Levin dele Geria	street and number)	HUSPIL	BULTI	more			y ol Death	city
1/4	Funeral Director		212-39-1003	7. Age (In yrs. 75	last birthday, Yrs.	Months Days	Hours N	Min. 8. Date of Birth (Month, Day	v, Year)	9. Birthplai Country	MD
	er death with the Maryland items 23a or 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMO		ty, Town or L				,	100	d. Inside City Limits
	with the	Director	10e. Street and Number 2618 PEARWOOD ROA	/D	,,,,	10f. Zip Code 212	21		10g. Citizen of	What Country	y?
920	72 hours atter death with the Maryland naturel', or items 23a or 28a-f ehow dissal Exacilias must be incilified at	by Funeral		12. Was Decedent Ever in U Armed Forces? 1 Mayes 2 No KO If Yes, Give Year or Dates:	REA			? (Specify Yes or No- uerto Rican, etc.)		ce - Americar ack, White, etc	c.
Maryland 21215-0036	d within giene. ir then	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired DRIVER	during most of	working	16b. Kind of E	Rusiness/Indu	stry
/land	be dail	To Be (	17. Father's Name (First, Middle, Last) BENJAMIN		СОН	EN	18. Mother's SARAI	Name (First, Middle, H	Maiden Sumai	<sup>me)</sup> YANKEI	_OVITZ
	s 1 and 2 should I Health and Mer Item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Ty GARY GRAZUTIES /					Rural Route Numbe		n, State, Zip C 21234	ode)
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	osition (Name of matory or other place ESHURUN		Date /25/2007	20c. Location	- City or Tow	
Balti	permit. Page Department of Importent: If eny injury or ance.		21. Signature of Funeral Service License			2. Name and Addre	ss of Facility		VINSON	& BROS	S., INC.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart lailure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deal ne cause on each line.  Advan  Due to (or as a consect	ad	ter the mode of dyin		diac or respiratory an	rest,	l I	opproximate nterval Between onset and Death
8760,	death certificate be executed e ettending physicien and ad for use as the buriel-transit	icai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consection of the consec							
P.O. Box 68	death certitic e ettending p ed tor use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnant   1	Ideath 3	□Ectopic pregnancy □ Other (specify)	,			ate of delivery onth D	ay Year
	law requires that the de as been signed by the 2 should be detached		Part II. Other significant conditions con		sulting in the u	inderlying cause give	en in Part I.				cause of death?
al Reco	The far ate has page 2	Completed by						24a. Was autop perfor 1 Tyes	sy med?	prior to comp death?	y lindings available pletion of cause of
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours alter death. To the Funeral Director, Alter this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Injun Worl	er: 4 🗆 Nursin	Death Check only or ng Home 5 Resid	lence 6 □Otl		
Divis	after dea after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of	ome, larm, st	reet, factory, office		28l. Location (S City or Tow		ber or Rural F	Route Number,
	To the Hospitet or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edical C	(Crieck only 21.) Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation in my of	pinion death o	occurred at the time of	tate and place	and due to th	ne cause(s)
9 11	To th Within To th compl	Me	29b. Signature and title of certifier	ัน คอ		29c. License	number 0 6 5	9/0	29d. Date signe	ed (Month, Da	ay, Year)
5	7		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,	Print)		110	Raltin	n(~c	2007
	Sta Registr		31. Date filed (Month, Day, Year)	and manner stated.  MD mpleted cause of death (Item 10 2414 32 Registrar's Signa	Thirte N ER 4	BURE P	carre	THYUNG,	1340113	·/ U E , )	<u>गा यायाड</u>

Division or Vital Records, P.O. Box 68760,

		For		State of Ma	ryland	d / De	partment of H	lealth an	d Mental Hy	giene	9	01000
	_	<ul> <li>State Registrar</li> </ul>	···			С	ertificate of	Death		Reg. No	2007	34383
Physicia	ın	Decedent's Name		ast)			Harrison	า	2. Date of De Month	Da		3. Time of Death 1215 P M
/Medica	Audi I	A Monte 4a. Facility Name (If		ive street and number)			4b. City, Town, o				County of Deat	<u> </u>
Funeral Director	3	Sinai H 5. Social Security No 212-79-	umber 6.	of Balta Sex 7. Age 1⊠M 2□F		ast birthda Yrs	Months Days	If Under 24 I	Hrs. 8. Date of Bir (Month, Date 05 14	ıv, Year	9. Birt	hplace (State or Foreign untry) MD
pu »		Usual Residence of 10a, State	Decedent 10b. County		10c City	, Town or						10d. Inside City Limits
e Maryla 3a-f shov tified at	ctor	MD	NA				nore					<b>X</b> □Yes 2□No
th with th 23a or 28 ast be no	Funeral Director	10e. Street and Nun 535 Lau		treet			10f. Zip Code	1217		10g. Ci	tizen of What Co	
al", o	व	11. Marital Status 1X Never Marri 3 □ Widowed	ed 2□ Married 4□Divorced	12. Was Decedent Ender Armed Forces? 1  Yes  If Yes, Give Year or Dates:		5. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🗶 No	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	)-	14. Race - Ame Black, Whit	
72 ho natur dical	eted	(Spec	15. Decedent's l		- 6	(G	cedent's Usual Occu	during most of	working	16b. k	Kind of Business	Industry
within ene. than "	Completed	Elementary/Secon		College (1-4or 5+	)	life	e. DO NOT use retire N/A	(d)			N/A	
ld be filed ental Hygi ked other ic event, ti	To Be Co	17. Father's Name (		st)			· · · · · · · · · · · · · · · · · · ·		Name (First, Middle nya John		n Surname)	
nd 2 shou lith and M 27 is mar r traumat	-	19a. Informant's Na				19b. M	ailing Address (Street 7 Park A	and Number o	r Rural Route Numb	er, City Ore	or Town, State,	Zip Code) 21217
ages 1 au ant of Hea t: If Item y or othe		20a. Method of Disp	osition	☐Removal from State	20b. Pl	ace of Disemetery, of	sposition (Name of crematory or other pla emorial	ce) Park l	Date 1/1/07		ocation - City or	
permit. P Departme Importan any injur	1	Signature of Fu			JKII		22. Name and Addr March F/ 4300 Wab	ess of Facility H West				21215
	1	23a. Pa /l. Enter th	ne disease, or co	mplications that caused to	he death							Approximate Interval Between
Physician /Medical		Immeriate Cause ( diser se or condition or Iting in death)				=/ <u>5</u> lence of):	yndrom	٤				Onset and Death 41/2 month.
Examiner and II-transit	Examiner	Immer late Cause (Final dise se or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										41/2 month
ficate be executed physician and s the burial-transit	edical E			d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal	death	3 □Ectopic pregnand 5 □ Other <i>(specify)</i> _	ey .			23d. Date of de Month	livery Day Year
w requires that the de been signed by the s should be detached	ž	Part II. Other signIf	cant conditions	contributing to death but	not resu	Iting in th	e underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
equire en sig ould b	bed 1	PREUMO							_ 1□	Yes :	2∏ NO 3□ P	robably 4 ☐Unknown
The law rate has be page 2 sh	Completed by	renal	dystu	nction					24a. Was auto perf 1∐ Yes		prior to death?	utopsy findings available completion of cause of s 2 □ No
certific ector,	Be	25. Was case referrexaminer?	,	Hospital:			Lot	26. Place of	Death (Check only	one)		
Phys er this eral dir	은	1 ☐ Yes 2 27. Manner of Deatl	h	28a. Date of Injury	/	ER/Outpa 28b. Tim	e of 28c. Inju	4 LI Nursii	ng Home 5 ☐ Res 28d. Describe			ecify)
ath. r: Afte	ation	1 Natural 2  Accident	5 ☐ Pending investigati	(Month, Day on	Year)	Inju		rk? ]Yes 2 ∐No				
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine		y - At ho (Specify	me, farm, ')	street, factory, office		28f. Location City or To			ural Route Number,
ne Hospit 1 24 hours ne Funera	edical (	29a. Certifier (Check only one)		Physician: To the best of aminer: On the basis of and manner stat	examinat							
To th within	M	29b. Signature and	title of certifier				29c. Licen				ate signed (Mon	
2 1	-	30. Name and addr	ess of person wh	o completed cause of de	ath (Item	23a) (Ty		2401	W. BElv.	Edl	Ere A	VE
( '		Thomas (		, M. D. Si.	nai	HOS	spital	Balti	mork,	md	2/2/	5
Stat Registra		31. Date filed (Mon			a Signa	2.			r			
MH 17 Rev 1/20			OCT 26	CUU/ Jacob	J. J.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34384 Reg. N2007 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ctober Day Year **Physician** RICHARD BRIGGS HASKELL 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □XM 2 □ F Director 042-32-7018 1929 Dec. 3, Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Harford Perryman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or the Medical Examiner must be 316 Fords Lane 21130 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygier
27 is marked other the 4 Military U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis (unk) Haskell Sr. Maude (nmn) Briggs Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra May Haskell / wife 316 Fords Lane, Perryman, Maryland 21130
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-26-07 Towson, Maryland ature of Funeral Service bicenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** er /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 No 1∐ Yes 2 No 1 Tes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 200

32 Registrar's Sign

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 24, 2007 2:35 A M Raymond John Haley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing and Wellness Center Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1X M 2□ F Hours 303-18-7016 89 Director October 19, 1918 Indiana Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 X Yes 2 ☐ No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 20850 1235 Potomac Valley Road United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Department of Health and Mental Hygiene. I file within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Franciscope. Black, White, etc. 1 Myes 2□ No Korea If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White 2 Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hydrologist National Weather Service 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Baptist Haley Mary Regina Megel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Anthony Street, Kensington, Maryland 20895 Rita Marie Haley / Daughter 20b. Place of Disposition (Name of cometery, crematory or other place National Memorial 20a. Method of Disposition 20c. Location - City or Town, State October 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Phoenix, Arizona 31, 2007 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. lette M01305 Mys 12 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanced Dementia /Medical Due to (or as a consequence of) **Examiner** Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending f 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an nas autopsy performed? /es 2X No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #201, Rockville, Maryland 20850 Sayed Elsayyad, M.D. 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 6 2007 Registrar

			1- For Amend Item 25 Registrar	State of M	arylan 886,1	2/05/6	artment of H 8dhb, 23d tificate of I	ealth and I Death	Mental Hy	giene 0	07	34386		
			1. Decedent's Name (First, Middle, Last	)					2. Date of De	aath		3. Time of Death		
	Physici /Medi		PAMELA JANE I	HOLCOMB					OCTOBE	ER 23, 2	2007	1:30 A M		
0	Examir		4a. Facility Name (If not institution, give Northwest Rehabi	street and number) Litation (	Cente	er	4b. City, Town, or	Location of Death	h	4c. Count Balti	y of Death MOre			
	Funeral Director		234-66-2633	х ]м <b>Ж</b> ] F	ge (In yrs. 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 15	ay, Year)	Cou	place (State or Foreign ntry) Virginia		
	land W		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
	Marylan -fehow lied at	to	Maryland Harford		,Tc	ppa						1 ☐ Yes 2 XNo		
	r 28s	Director	10e. Street and Number			ppu	10f. Zip Code			10g. Citizen of	What Cou	ntry?		
	deeth with the Maryla eme 23a or 28a-f ehov		103 Fort Hoyle H	Road			21085			USA				
2	er deeth w iteme 23a	Funeral		12. Was Decedent Armed Forces?			Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No o Rican, etc.)		ce - Ameri	can Indian, etc.		
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PAM6	within 72 hours atter deeth with the Maryland ene. then "natural", or iteme 23s or 28s-f ehow the Medical Examinative motilied at	ted	15. Decedent's Edu	cation		16a. Deced	ent's Usual Occupa	ation		16b. Kind of 8				
215	thin 7 en "n Med	Completed	(Specify only highest grad	e completed) College (1-4or 5	5+)	(Give	kind of work done of OO NOT use retired	furing most of wor )	king					
21	e filed wi al Hygien I other th vent, Lte		12			Homem	aker			Own Ho	2112			
ο and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last) William Russell	Holcomb	Sr.			18. Mother's Nan Susan V	ne (First, Middle Victoria		- 1			
Colcomb	s 1 and 2 should be filed within 72 hours if Health and Menial Hygiene. Item 27 is marked other then "natural; other traumatic event, the Medical Exa	우	19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street a					Code)		
	1 and 2 Health a em 27 is		Phyllis Lewis / Si	ster			ort Hoyle							
- Baltimore,	of He of He filter		20a. Method of Disposition  12 ☐ Burial 2 ☐ Cremation 3 ☐ F	lamoval from State	20b. P	lace of Dispos	sition (Name of natory or other place		Date	20c. Location				
Ĕ	Pag ment tant:		4 ☐ Donation 5 ☐ Other (Specify)		Har	ford M	emorial (	rdn 10-2	25-07	Aberdee	n. Ma	ryland		
Bai	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.	Harford Memorial Grdn 10-25-07  21. Signature of Fundal Service Licensee  WCConds Fundal Service Licensee  1317 Cokesbury Road, Abin												
			23a. Part1. Enter the disease, or compli	ications the caused	the death						aryla			
	Physician		Approximate shock, or heart failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Sease or condition  Approximate Interval Between Onset and Death Sease or condition  Approximate Interval Between Onset and Death Sease or condition  Approximate Interval Between Onset and Death Sease or condition  Onset and Death Sease or Condition  Approximate Interval Between Onset and Death Sease or Condition  Onset and Death Sease or Condition  Approximate Interval Between Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death Sease or Condition  Onset and Death											
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8760,	cate be executed ohysician and the burial-transit	dical		Meg	Hal	vetavo	lation	CERTIFICATI	N					
9	h certifica anding ph use as th	au I	IF FEMALE:	100										
80	attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal	death 3 🗌	Ectopic pregnancy				ate of delive	ery Day Year		
o.	thet the death ed by the atte detached for	iysic	1 □ Yes 2 □ No 9 ☑ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5∐	Other (specify)							
<u>a</u> .	res thet the igned by be detact	Completed by Physician/M	Part II. Other significant conditions cor	tributing to death be	ut not resu	ılting in the un	derlying cause give	n in Part I.	23e. Did t	obacco use cor	tribute to t	he cause of death?		
rds	w require been sig should b	ed t							1 🗆 '	Yes 2 No	3 Prob	oably 4 Unknown		
eco	e law ri has be ge 2 shi	ple							24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of		
<u> </u>	: The									med? 25 No	death? 1 ☐ Yes			
Vit.	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	ospital:			Othe	26. Place of Dea						
o	g Phys ter this neral di	n: To	27. Magner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 Nursing H	ome 5 Resident	dence 6 □Oti how injury occu		(y)		
ion	uttending I death. ctor: After y the tuner	atio	1/25Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Yeer)	Injury		? ′es 2 □ No						
Division of Vital Records, P.O. Box	al or Attending Physicien: The law requires that the death certifics atter death.  I Director: After this certificate has been signed by the attending it in by the tuneral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specify	me, farm, stre	et, factory, office		28f. Location ( City or Tou	Street and Num. wn, State)	ber or Rura	al Route Number,		
		Medical C	29a. Certifying Phys (Check only one) Certifying Phys 2 Medical Examir	sician: To the best of ner: On the basis of and manner sta	examinat	wledge, death ion and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	, and due to the rred at the time,	cause(s) and m date and place,	anner as s and due to	tated. o the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signe	ed (Month,	Dey, Year)		
	/		1 Lu	3,90			HO	06426	7	10 -	23-	0)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Kalen Custin Bar Bar Under My.							10.06.		2 0 4	201				
	Sta	e	31. Date filed (Month, Day, Year)	32 Registra	ur's Signat	ure Do	1 unal	11 677.	Bouled	ve jour	+ 1/0	+0/		
	Registra		OCT 2 6 20	AND THE PERSON NAMED IN	as A	> fage	MAL							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #30,perDVR,g872, 10/26/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bernice Mattie Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 5, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Virginia Months Days Hours Min. 1 M 2 TE 79 Director 225-66-9289 Usual Residence of Decedent r 28a-f show notified at 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Prince George's Maryland Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or 2 liner must be n 20770 7732 Lakeside Avenue U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian "natural", or iten edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maid Cleaning/Self Employed permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy Johnson Bessie Trent ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jackson (Son) 1785 Clarkson Rd., Richmond, VA 23224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Baptist 10/20/07 Columbia, VA 21. Signature f Funeral Service Nicensee 22. Name and Address of Facility Sheridan Funeral Home 6093 Venable Rd., Kens Store, VA 23084 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4- Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an director, page 2 Hospital or Attending Physician: The 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ္ 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Hector Knox, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, D

Day, Year)

2007

3. Registrar's Signature

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3, 2007 Physician OCTOBER 2:12P Hoert Lugene /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Saint Joseph Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 № M 2 □ F 216-18-0016 Director Baltimore, mo Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 □Yes 2 k No Director altimore arkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21 23a · death v Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Nes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced "natural", White Completed or than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Jacobs Hissociates Elementary/Secondary (0-12) College (1-4or 5+) 12 mplayeec 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 dmuno 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is m any injury or other traum once. Blyd 8820 Walther Apt 452) Kuth Jacobstarkville Md 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

Machand Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10-26-2007 Baltimore, md 4 □ Donation 5 □ Other (Specify) Cometary Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services-Parkville
8800 Harford Ruad Parkville md 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed SEPSIS burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician at the burial Physician/Medical PNEUMONIA attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

LOW

OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

7601

Registrar's Signature

D24034

TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year JOHN SON EARL AVID 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1A MedicaL NIA BALtimore 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**№** M 2□ F Months Days Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits at r 28a-f sh notified 1 XYes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? ms 23a or 2 must be n "natural", or items 23a 15A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Examiner Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 Married 2 🗆 No Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed : 1 and 2 should be filed within 72 hd Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 +HGRADE ABORER SPARROWS HOINT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LARENCE မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARENCE LANVALE If item 27 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Injury or Important: I any Injury o 4 Donation 5 Other (Specify) OWINGS MILLS, BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR. FUNE 2P45 N. FULTON AVE. BALTO. MD. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory rrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ELEVATION MOCARDIAL T Physician /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Ş Q myeL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed' certificate 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Yes 2 No Certification: To 1 Ampatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kim R Bizze LL ION CREENE Street BALTimure, MD 2120/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 6 200 Registrar

				For State Registrar	State of M	arylan	-	artment o				giene 0	7	34390
o		Dharaini		Decedent's Name (First, Middle, Last)							2. Date of De.	ath Day	Year	3. Time of Death
-		Physici /Medi		LeRoy E. Johnson							OCT	.20 2	2007	0552M
N		Examir	ner	4a. Facility Name (If not institution, give st				4b. City, Tow		on of Death		4c. County	of Death	
5.5				Atlantic General F. 5. Social Security Number 6. Sex		no (In ure	last birthday)	Berli		ler 24 Hrs.	8. Date of Birt		ceste:	r lace (State or Foreign
)5		Funeral Director			M 2□ F	57	Yrs.		ays Hour		(Month, Da	, 1950	Coun	
7 (		פ		Usual Residence of Decedent										
DD		arylar ehow	-	10a. State 10b. County			y, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
1-		he Mi	Director	MD Berlin  10e. Street and Number		Wo	rceste				1	10- 00		21.
_		with t	ă	10434 Jones Road				10f. Zip Cod	2181	1		10g. Citizen of	what Coun SA	itry?
10		Jeeth Teeth	Funeral		2. Was Decedent	Ever in U.	S. 13. \	Was Decedent f Yes, specify (			ify Yes or No		e - Americ	an Indian,
10	9	or iter	F	1 Never Married 2 Married	Armed Forces?	No.		_			tican, etc.)		ck, White,	
7	03	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🔀	No Speci	rry:		Specify	y whi	te 
3	5-	within 72 hours after deeth with the Maryland ane. than "natural", or iteme 23e or 28e-f ehow he Medigal Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ation co <i>mpleted)</i>		(Give	dent's Usual Od kind of work do DO NOT use re	one during m	nost of workin	g unk	16b. Kind of B		
à	12	withir Bne. than	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	//re. L	DO NOT use re	etirea)			town of	0cea	n City
DOD; 10/2010	<b>d</b> 2	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>		l		18. Mo	ther's Name	(First, Middle,	Maiden Suman	ne)	unk
	lan	lid be fental rked ric ev	To Be	Robert Irvine John	nson									
20	Maryland 21215-0036	and Management		19a. Informant's Name/Relationship (Type	e, <i>Print</i> )		19b. Mailin	ng Address (Str	reet and Nun	nber or Rural	Route Numbe	er, City or Town,	State, Zip	Code)
3/		and 2 ealth n 27 i		Pamela Johnson/spo	use			4 Jones			in, MD	21811		
1	Baltimore,	T of H H iter		20a. Method of Disposition  1 Burial 2 Cremation 3 Rei	moval from State		lace of Dispo emetery, cren	sition (Name o natory or other	of place)	Da	ite	20c. Location -	· City or To	wn, State
-	ij	tant:		4 Donation 5 □ Other (Specify)	/7					1				
DOB: 1/23/50	Bal	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow enty injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Euneral Service Licensee ROTA	ade Dir	ector		ate An				Baltim	ore S	treet
				23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused cause on each li	d the death						rrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition		4 9	ier fo	illur	0					Onset and Death
,	4	Physician /Medical Examiner		resulting in death)	Due to (or as			•						
Sh			-	Sequentially list conditions, b.	Due to (or as	1 conseque	alitis							
3		uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00	A 1	oholi	SW						
7	o	exection and and rial-tra		that initiated events c. resulting in death) Last	Due to (or as	a consequ	uence of):		1 4 4	1	***			
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5	9	certifica nding ph use as th	Med	IF FEMALE:						/				
311	Вох	wrequires that the death certifi been signed by the ettending should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1 Live birth	2 Fetel	death 3	Ectopic pregna					ite of delive	ory Day Year
	o.	The law requires that the death sie has been signed by the etter bage 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	t time of de	eath 5L	Other (specify	y)					,
共	<u>α</u>	that the the the the the the the the the th	y Ph	Part II. Other significant conditions contr	ributing to death b	out not resu	ulting in the ur	nderlying cause	e given in Pa	ırt I.	23e. Did to	obacco use cont	inbute to th	ne cause of death?
\$\$\$	rds	quires n sign ald be	d by								101	res 2□No	3 🗆 Prob	ably 4 Stinknown
111	00	law recast bee	olete								24a. Was	an 24b.	Were auto	psy findings available inpletion of cause of
7	of Vital Records,	riclan: The lav certificete has rector, page 2	Completed								autop perfo	rmed?/	death?	npletion of cause of 2□ No
eny	ita	ilan: artifice ctor, p	Bec	25. Was case referred to medical examiner?					26. Pla	ace of Death	(Check only o			
d	<u>&gt;</u>	Physician: this certific ral director,	P	1 ☐ Yes 2 ☑ No Ho	spital: 1 🗖 Inpatie		ER/Outpatien					dence 6 Oth		v)
114	'n	ding P	lon;	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury		Injury at Work?		8d. Describe f	now injury occur	red	
0	Division	Attending r death. octor: Afte	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	iuny - At bo	ome form str		1 ☐ Yes 2		Rf Location (	Street and Numb	her or Rum	I Route Number.
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Johnson:		To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine	er: On the basis o	of examinat	wledge, death	occurred at th	ne time, date my opinion, d	and place, and death occurred	nd due to the	cause(s) and ma	anner as si	tated. o the cause(s)
		thin 2 the omplei	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Lic	cense numbe	er		29d. Date signe	d (Month.	Dev. Year)
		T vil		) Co Con	he	(A	11.	7	D54	312		10/201	,	
				30. Name and address of person who com	pleted cause of o	leath (Item	123a) (Type	Print)				10/20/	1	
				29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who com  30. Name and address of person who com  31. Date filed (Month, Day, Year)  0CT 2 6 2007	, MD 9	733	Healt	herry !	Drive	Berlin,	MD 2	11811		
		Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture	100 p						
		Registr	ar	OCT 2 6 2007	12/20 12	Ar	AS ALL							

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Funeral Director: stely filled in by the

Certification:

Medical

27. Manner of Death 1 Ziniatural

2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and

the 2

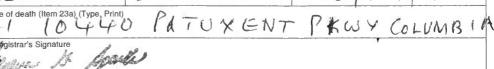
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Dégistrar's Signature

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.



28c. Injury at Work?

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

063145

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Cecil

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Zweels

Day

Year

1 □Yes

21/No

Maryland

White

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day October 17 **Physician** 2007 Charles R. Kwasnik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital Elkton 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Director Feb. 1934 215-30-4446 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at Timonium Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. 21093 United States OF America 3 Elphin CT. 101 Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 27 No Baltimore, Maryland 21215-0036 1 Yes Specify. Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the and Mental Hygiene.

7 is marked other than "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cyamid N/A Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Polanowski Thaddeus Kwasnik ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any Injury or other tra Barbara Powell- Daughter 3 Elphin Ct. 101. Timonium Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Oct. 20,2007 Gardens Of Faith Rosedale, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License EVANS FUNERAL CHAPEL AND CREMATION SERVICES 8800 Harford Road Parkville Maryland 21234 tationa O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute and chronic respiratory tailone /Medical Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes C+ (Wie 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only on 1 Yes 2 No 1 Manatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Autural 2 Accident 28b. Time of 28a Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00055190 October 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital, 106 Bow Street, Elkron, MAD 21921 A PINO MO

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25, 2007 October 6:47 P Naomi C. Kirwan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🛣 F Director 213-34-8502 89 Sept. 10,1918 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be 21236 U. S. A. 4300 Cardwell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Lloyd Albert Kinzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12030 Tralley Rd., Unit 304, Timonium, Md. 21093 Patricia Lamdin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/ 29/2007 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd., Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2X No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 💢 Natural 5 Pending investigation Injury i or Attendin after death. I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 6 2001

32. Registrar's Signature

KA HARA

			State of Maryland / Department of Health ar  1- State Registrar  Certificate of Death	nd Mental H	lygiene Reg. No. 200	7 34394	
	Physicia /Medic Examin		Decedent's Name (First, Middle, Last)	2. Date of I	Death	3. Time of Death	
8			Sandra E. Kruth	Octob			
			4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death				
	Ni projection of the second		300 Prettyman Drive, #12101 Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of	Montgom	ery irthplace (State or Foreign	
	Funeral Director			Min. (Month,	Day, Year)	country)	
+			Usual Residence of Decedent	12/10	7/1775		
	inylani ihow I at	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 🏋 Yes 2 □ No	
	Ba-f s	Director	Maryland   Montgomery   Rockville				
	a or 2 be no	Ö	10e. Street and Number 10f. Zip Code		10g. Citizen of What	•	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. If health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	eral	300 Prettyman Drive, #12101 20850  11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin	n? (Specify Yes or	United Sta	nerican Indian,	
98		by Funeral I	11. Marital Status  1	Puèrto Rićan, etc.)	Specify:	nite, etc. Thite	
9		ted	15. Decedent's Education 16a. Decedent's Usual Occupation	of committee	16b. Kind of Busines		
215		ple	(Specify only highest grade completed)  [Specify only highest grade completed]  [Give kind of work done during most of life. DO NOT use retired]	of working	100		
2		Completed	4 Homemaker		Own Ho	ome	
Maryland 21215-0036	be fill ntal H ed oth even	Be	, ,	s Name <i>(First, Midd</i> .a Freeman	dle, Maiden Surname)		
Σ	d Men narke	ပ္	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number			Zin Code)	
Ma	nd 2 s Ith an 27 Is u		Howard S. Kruth / Brother 401 Feather Rock Dri				
d)	s 1 ar f Hea item ;		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	or Town, State	
Ë	Page nent o nt: If ny or		4 Donation 5 Other (Specify) Norbeck Memorial Park 10			ryland	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee  M01346  22. Name and Address of Facility Bethesda-Chevy C Bethesda, Maryla	Robert A. hase Inc	Pumphrey F	uneral Home/ consin Ave.	
97	4,		23a. Part : Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause on each line.			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Breast Cancer			Onset and Death	
	/Medical		resulting in death) Due to (or as a consequence of):				
2 <sub>72</sub>	Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
	red red	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liscaec or high) that initiated events resulting in death) Last  Due to (or as a consequence of):  C				
$\pi_{j}$ ,	al-tra	Examiner	that initiated events c c Due to (or as a consequence of):				
68760%	iicate be executed physician and s the burial-transit	dical	d				
-	rtificat ng phy as th	Medi					
Вох	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of o	delivery Day Year	
0			1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 ☐ Unknown		-	Day Tour	
Δ.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco use contribute	to the cause of death?	
Vital Records,				1	□Yes 2XINo 3□	Probably 4 □Unknown	
00	w require been significations			24a. W	as an 24b. Were	autopsy findings available	
Re	The lav	шo		pe	erformed? death	to completion of cause of ? es 2 □ No	
ta	ng Physician; Iter this certifica ineral director, p	a l	25. Was case referred to medical 26. Place of	1  Ye of Death (Check on	21	es 2 No	
<u> </u>		0 8	examiner? 1   Yes 2   No	sing Home 5 🔀 R	esidence 6 □Other (S	pecify)	
n or		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at Work?		be how injury occurred		
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation M 1 Yes 2 No		(0)	8 -10 - 11 - 1	
Division	or At after d Direc in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	City or	n (Street and Number or Town, State)	Hurai Houte Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated				
	o the o the o the omble	Med	one) and manner stated.  29b. Signature and title of certifier 22c. License number		29d. Date signed (Mo	onth, Day, Year)	
	H S F ŏ		►/14 MMC/ m.D. 53177		October 25	, 2007	
	. (		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	15		I 1 M-11 M D 0707 Medical Contan Deisco #	300, Rock	ville, Mary	land 20850	
	Sta		31. Date filed (Month, Day, Year) OCT 2 6 2007  OCT 2 6 2007  OCT 2 6 2007				
	Registi	rar	OUT A U COUT JOSEPH CONTRACTOR OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SAMENDI MATAMARA POZGA MATAMININ SARITANIA ARATANIA tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Vere 2007 1c tobe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North andalls town Ral 10Mit Welt HOSPITA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☑ M 2 ☐ F Director 01/06/1946 124-36-1325 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 Hayward Avenue by Funeral 21215 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Warehouse worker Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Richard Little Leola Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau Gina Crawford / Daughter 4107 Hayward Ave., Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2007 Metro Crematory, Inc. Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fanl Respiration /Medical Due to (or as a consequence of): Examiner Atherosel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be execute burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performe 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3DX DOA Certification: To After this funeral 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Naturai 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 56430 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Rd 2113.3 OP r0 Randallitown 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 6 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / De 1 - State Amend Items 24a,25 per dr.	partment of Health and N 2872-10/26/07dhb ertificate of Death	ental Hygie Reg	ne . No 2007	34396
Ų.	Diversite!		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Oct. 18 Day 2007 Jear /0:3004M			
	Physici /Medic		Cleo J. Lewis			Day 2007	10:30 pm
1	Examiner		4a. Facility Name (If not institution, give street and number)		4c. County of Death		
	1		Ivy Hall Nursing Center	Middle River	R Date of Birth	Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min	8. Date of Birth (Month, Day, Y) July 12	(ear) 1922 PA	ace (State or Foreign try)
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	MD Baltimore Midd	le River			1 ☐ Yes 2 No
		irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
36		al D	2135 Redthorn Road	21220		USA	
		by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☐ No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of Specify: Wh:	etc.
Š		ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	16	ib. Kind of Business/Inc	ustry
21215-0036		To Be Completed		ive kind of work done during most of work a. DO NOT use retired) .itress		MArtins	
			17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Surname)	
/lan			Bud Humes	unkno	wn		
Maryland				alling Address (Street and Number or Rui 3 N. Woodward Dri			
Baltimore,			20a. Method of Disposition  1½ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Dicemetery, of Holly	sposition (Name of prematory or other place) Hill Cemetery 1	Date 20 0 / 2 2 / 0 7	e. Location - City or To Baltimore	wn, State MD
Balti			21. Signature of Funeral Service License	22. Name and Address of Facility  Connelly Funera		Ave.Balt	
	Physician /Medical Examiner	8 1	23a. Part1. Enter the disease or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate
100			Immediate Cause (Final disease or condition	- BRONCHA	CHIL	15	Opset and Death
100			resulting in death)  Due to (or as a consequence of):	Carrolina	1 10	21	40 1000
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
ds, P.			Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	
Vital Records,					24a. Was an autopsy performe	prior to cor	osy findings available npletion of cause of
a			OF Man ages referred to modical		1  Yes 2	XNo 1 ☐ Yes	2□ No
			25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Oil .	th (Check only one)	ce 6 ☐Other (Specify	
9			27. Magner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how		7
io			2 Accident investigation	M 1 Yes 2 No			
Division			3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
			29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cau rred at the time, date	ise(s) and manner as si e and place, and due to	ated. the cause(s)
			29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month,	
			11000	111128	/ (	0-20-2	2007
	(m)		30. Name and address of person who completed cause of death (Item 23a) (Tyles A YLN OUNG MD 802	2BECAIR	ROA	8, NOTT	NGHAM 236
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 6 2007							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 0 **Physician** 2007 Leutritz 12:20 A M Elizabeth Ann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 537 St. Francis Road Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗙 F 218-30-5461 89 Director 1/6/1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☑ No Baltimore Towson Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 21286 U.S.A. 537 St. Francis Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ White 3 X Widowed 4 □ Divorced r than "natural", the Medical Exa Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Physical Education Teacher Teaching of Health and Mental Hygie I Item 27 is marked other t r other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Cora Willis Allen Moore Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann L. Blucher / Daughter 537 St. Francis Road Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 10/26/07 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp Towson, MD 21. Signature of uneral Service Lice 22. Name and Address of Facility Towson, Maryland 21204 1050 York Rd. Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each y e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final arcin **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: variete death.

Jurs after death.

Jurs after this certification by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Deal 1 D Natural 2 □ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier (Excritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and proponer stated. 29d. Date signed (Month, Day, License numbe 29b. Signature and title of certifier 30. Name and address of person with propleted cause of death (Item 23a) (Type, Print) -SSam 31. Date filed (Month, Day, Year) strar's Signature State 2 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** nda A. Malavarnera 051 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shock Trauma ary land, Baltimora niv 0-If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 1 F Connecticut 040-42-5955 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director Ohio Franklin Worthington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 256 E. Granville Road 43085 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White è 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School Human Resources Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic evone. Emily Kongebol ဂ George Skinner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Granville Rd., Worthington, OH 43085 256 Ε. <u> Salvatore Malguarnera (Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 La Cremation 3 ☐ Removal from State 5 Other (Specify) Metropolitan Crematory 10/18/07 Alexandria, VA 4 ☐ Donation 22. Name and Address of Facility
Schoedinger Mortuary
6699 North High St., Worthington, OH 43085 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Suparachno Physician MVC /Medical to (or as a consequence of): Examiner anoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CERTIFICATION AND OVED BY The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Nnknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2∏ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28d. Describe how injury occurred Subject passing That Struck a q Date of Injury (Month, Day Year) 28b. Time of Injury 5 ☐ Pending investigation 1 Natural 2:53 1 10-13-2007 1 TYes within 24 hours after deau...

To the Funeral Director: / 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify) farm, street, factory, office Location (Street and Number City or Town, State) 4 ☐ Homicide Koadway

Rute 214

Cumberland: Mar

\*\*Mark Continuous Control of the Desis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cumberland, Maryland To the Hospital 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar the Marcolini

31. Date filed (Month, Day, Year)

OCT 2 6 2007

7.2 Greene

Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 1750 October 24, Dorothy Myer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Hours 1 ☐ M 2 🕅 F 84 30, 1922

**Funeral** Director

**Physician** 

/Medical

Examiner

r 28a-f show notified at 23a or pe

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must I

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

be executed

Box 68760,

P.O.

Records,

Division or Vital

Physician:

Attending

Examiner burial-transit and attending physician Physician/Medical the 2 Completed certificate has Be ျ this funeral After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. completely filled in by the

Anne Arundel Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 579-20-9006 Washington, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TxYes 2 TNo MD Director Arnold Anne Arundel 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21012 USA 628 Oakland Hills Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Finance Home Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator Economics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Jennes ည Mary Bucci 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores A. Fox - Daughter 979 Forest Dr. Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hedges Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/29/07 Hedgesville, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 327 W. King St. Brown Funeral Home Martinsburg, WV 25401 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espirator Due to (or as a consequence tastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Farrokh Sohrabi, M.D.

26

2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Anne Arundel Nedical Center

21401

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2007 October 0 Peyton Newton George 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 37 Baltimore Gilchrist Center For Hospice Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F Months Days Missouri 70 500-34-3617 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21043 8790 Stonehouse Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: 3 ♥ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine George Newton Long Neil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Parkton, Maryland 21120 19820 York Road Son <u>Jeffrey N. Newton</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 10-26-2007 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) tur Fun ral Selvice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sclernsis disease or condition resulting in death) eno Due to (or s a consequence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Yes 2 No PICE

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sh Examiner must be notified

permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event e

Director

Funeral

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Completed

Be

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/Medical

10a. State

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a page 2 or Attending Physician:

P.O. Box 68760,

Division or Vital Records,

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

certificate completely filled in by the funeral After after death.

5 ☐ Pending investigation

6 ☐ Could not be

27. Manner of Death 1 ☑ Natural

2 Accident

3 Suicide

31. Date filed (M

4 ☐ Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 🗌 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29d, Date signed (Month, Day, Year)

who completed cause death (Item 23a) (Type, Print)

2007

egistrar's Signat

State Registrar

To the Hospital o within 24 hours aft To the Funeral DI

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** October 21, 2007 0130 Barbara G. Nuttycombe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 1 F 228-40-0191 81 April 25, 1926 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 North Leisure World Boulevard 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pest Control Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Eugene Gerhart Mary Elizabeth Hamilton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Cochran / Daughter 18425 Azalea Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 30, injury or 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2007 Bethesda, Maryland ert A. Pumphrey Funeral Home/ West Montgomery Avenue, 20850-2805 21. Signatule of Funeral Service. 22. Name and Address of Facility Robert Rockville, Inc., 300 W Rockville, Inc., 300 Rockville, Maryland M01473 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Pan1. Enter the diseashock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** speatdial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/No 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/10 Inpatient 2 2 ER/Outpatient 3 DOA ours after death.

neral Director: After this filled in by the funeral d Manner of Death 28a. Date of Injury 28h Time of Certification: Injury at Work? 28d. Describe how injury occurred atural (Month, Day 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifi 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) PRINCE 20837 18101 KADIM 31. Date filed (Month, Day, Year) State OCT 2 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

chard William		1- For State Certificate of Death	Mental Hygiene 2007 3440
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year October 11, 2007  Reg. No.  3. Time of Death 0858 hrs
		4a. Facility Name (if not institution, give street and number)  Marshall Hall Park  4b. City, Town, or Loca  Bryans Road	
Funeral Director		, dine	Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Hours Min. July 10, 1953 Foreign CountryNew York
r death with the Maryland or items 23a or 28a-f show any must be notified at once,	Director		10d. Inside City Limits 1 Yes 2 X No  10g. Citizen of What Country?  USA
ırs after death witl ural", or items 2 miner must be n	by Funeral	3 Wildowed 4 X Divorced in res, Give real 1 Yes 2 X No specification or Dates:	corigin? (Specify Yes or No- exican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
5-0036 ed within 72 hou ygiene. other than "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO  12 0 machinest repai  17. Father's Name (First, Middle, Last)	NOT use retired)
AD 21215 2 should be file 1 and Mental H. 27 is marked of matic event, ti	To Be (	Robert Newey  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and	ane McCarthy d Number or Rural Route Number, City or Town, State, Zip Code) Orive Montgomery, AL 36117
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 X Other Specify: in state  21. Signature of Funeral Sorvice Licensee  22. Name and Address of Funeral Sorvice Licensee	ry, Date 20c. Location - City or Town, State
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	h 21201
e executed yan and jal - transit	dical Examiner	if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.	
lox 68760, leath certificate be attending physic for use as the bur	影	UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  23c. if yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery  Ectopic pregnancy  Month  Day  Year
cords, P.O. E law requires that the d has been signed by the 2 should be detached	Ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	a in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown  24a. Was an autopsy Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4  Probably 4
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 s	Be Completed	25. Was case referred to medical examiner? Hospital: 4 Post at 2 FD/Outpeticet 3 Post Other	performed? death?  1  Yes 2  No 1  Yes 2  No  Death (Check only one)
	Certification: To	27. Manner of Death  28a. Date of Injury  County Day, Year)  28b. Time of Injury  28c. Injury at	Work? 2 ✓ No  28d. Describe how injury occurred Subject shot self
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date an one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	and place, and due to the cause(s) and manner as stated.
		29b. Signature and title of certifier  29c. License nur  O.C.M.E	
	ate	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore,  31. Date filed (Month, Day, Year)  32. Registrar's Signature	MD 21201

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of M	aryland / i	Department of Certificate	of Health and of Death		en2007	34403
			1. Decedent's Name (First, Middle,	Last)		-		2. Date of Death		3. Time of Death
	Physic /Medi		Barbara Pauline	Owens				Month 10	Day Year 23 2007	8:55 AM
	Examir Funeral Director		4a. Facility Name (If not institution, g Cousta   Hos 5. Social Security Number 216-07-5261	ice at 4	Le Lak ge (In yrs. last bi	thday) If Under 1 Y	vn, or Location of Deal	8. Date of Birth	Year) Co	
	D		Usual Residence of Decedent		1			1.0 7.3		
	show	-	MD Wicomi		10c. City, Tow					10d. Inside City Limits
	8a-f	Director		CO	Sali	sbury		1		1 Tyes 2 No
	a or	ä	10e. Street and Number 219 Troopers Wa	57		10f. Zip Co		10	g. Citizen of What Co	untry?
	leath	era	11, Marital Status	12. Was Decedent	Ever in U.S.	13 Was Decedent	of Hispanic Origin? (5	Specify Yes or No-	USA 14. Race - Ame	rican Indian
326	be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or items 23e or 28s-f show event, the Medical Exam had made a purified at	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify  1 ☐ Yes 2∑	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	to Rican, etc.)	Black, White	e, etc.
5-0036	2 hou	Completed	15. Decedent's	Education	16a	Decedent's Usual O		. 10	6b. Kind of Business/	Industry
215	thin 7	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use re	one during most of wo atired)	rking		
2	filed withi Hygiene. other than	Con	10	0		homemak			own hom	e
nd	0 to 5	Be	17. Father's Name (First, Middle, La	•			18. Mother's Na	me (First, Middle, Mi	aiden Sumame)	
yla	should be nd Mentat marked o	은	Marion Cadmus B	,				mma Dishar		
ā	and and is m	N i	19a. Informant's Name/Relationship				reet and Number or Ri			ip Code)
	1 and 1 ealth 3m 27 ther tr		Sally Owens/dau 20a. Method of Disposition	ghter		19 Trooper	s Way Sali			
Baltimore,	Peg nent ant: h		1 ☐ Burial 2 ☐ Cremation 3  '4 ☑ Donation 5 ☐ Other (Special	cify)	cemete	ry, crematory or other	place)		0c. Location - City or	
Ba	permit. Departr Importa any inje		21. Signature of Puneral Service Lice Ronal A S	1 Jul		Baltimor	atomy Boar e, MD 212	01		Street
4. 1	Physician		23a. Partt. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each li	the death. Do	not enter the mode of Renz		c or respiratory arres		Approximate Interval Between Onset and Death
(金)	/Medical Examiner		resulting in death)	Due to (or as	a consequence		4 047			
	pe tiis	iner	Securitally list on ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as	a consequence	of):				
ð,	fficate be executed physician and st the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence	of):				
09/8c	ficate b physic s the b	edical		d						
O. Box	e death cert he attending sed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregni 5 □ Other (specif)			23d. Date of deli Month	very Day Year
ords, P	es ign be	by	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
2	stcian: The law requir certificate has been s irector, page 2 should	Completed						24a. Was an autopsy perferme	prior to death?	topsy findings available ompletion of cause of
	tifical	0	25. Was case referred to medical				26 Place of Dog	1 Yes 2 ath (Check only one)	No 1 ☐ Yes	20 No
>	Physician: this certific ral director,	O.B	examiner?	Hospital:	ent 2 ER/Ou	tpatient 3 DOA	Other		ce 6 □Other (Spec	(fv)
	nding Ph tth. :: After thi e funeral	ation: T	27_Maprier of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da		ime of 28c. i	njury at Work? 1 □ Yes 2 □ No	28d. Describe how		
DIVISION	s after des bl Director d in by th	Certification:	3 Suicide 6 Could not determine		ury - At home, fa c. (Specify)	rm, street, factory, off	ice	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	o the nospitel of Attending Physician: with 24 hours after death. To the Funarel Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier Check only one) 1 Certifying F Medical Ext	Physician: To the best aminer: On the basis of and manner sta	examination an	, death occurred at the	e time, date and place ny opinion, death occu	o, and due to the cau arred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
i	Withii To 18	Σ	29b. Signature and title of certifier	1111		29c. Lic	ense number	290	d. Date signed (Month	, Dey, Year)
			CHUZ	UV.	MI		1262	78/1	10-234	7
	100		30. Name and address of person who	completed cause of d	eath (Item 23a)		0. 0	1222 0	//	100165
			David E. Com	11, MD C	sustal.	HOSPIK.	PO BOX 1	155 5	alish, W	1021802
	Sta Registr	×2	31. Date filed (Month, Day, Year)  OCT 2 6 2	32 Registra	ar's Signature	Cooles				

State Registrar 31. Date filed (Month, Day, Year)

RAMOAUSTOLOW

CEMTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 2007 CTOVIO October 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Johns Baltimore HOOKins 8. Date of Birth (Month, Day, Year) Sept. 15, 1939 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 <del>Q</del> M 2 □ F Hours 68 Columbia 229-68-5644 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2 ☐ No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9900 Sorrel Avenue 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1969-1971 1 ☐ Never Married 2 ☑ Married 1x Yes 2□ No SpecifyColumbian Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Doctor Neurosurgeon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alejandro Polanco Maria Rodriguez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melba Polanco/ Wife 9900 Sorrel Avenue, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State October 25, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 Crematorium Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rocville Inc., 300 West Montgomery Avenue Rockville, Maryland 20850 M01498 Luner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 days Ineumonia Due to (or as a consequence of): Interstitial Pulmonary Fibrosis Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

Be Completed by

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar models.

Baltimore, Maryland 21215-0036

the

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760.

Physician/Medical Examiner Completed by Be Medical Certification: To

State

29b. Signature and title of certifier Daniel Ditstoop Mos

6 ☐ Could not be

3 Suicide

4 ☐ Homicide

(Check only

29c. License number RES-000

156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

October 21,2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital 600 North Wolfe Street Baltimore, Maryland

31. Date filed (Month, Day, Year)

OCT 2 6 -2007

Johns Hopkins
32. Megistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

# Baltimore, Maryland 21215-0036

			For State	State of Maryla				Mental H	ygiene		
	S	-	1 State Registrar  1. Decedent's Name (First, Middle, Last)		Certific	ate of D	eath	1 0 D-1 - (D	Reg. No.2	07	34406
667	Physici	an						2. Date of D Month	Day	Year	3. Time of Death
	/Medi Examir		Louis Leo Pay  4a. Facility Name (If not institution, give s		4h (	City Town or I	Location of Dea	Duop		ty of Death	7 7 401
100	Examin	IEI	BALTIMORE LOASHI		MINA (ED	TE 2	Gen	12000	Λ.	FNE	ARINA
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs	s. last birthday) If U	nder 1 Year   ths Days	If Under 24 Hrs Hours Min			9. Birth	place (State or Foreign
	Director		/10-09-6919	M 2□F 86		uns Days	nours Mill	05/22		Coui	MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location						10d. Inside City Limits
	daryli f sho ed at	ō		Arundel	,		0	-		- [	1 ☐ Yes 2 ☑ No
	the tage 28a-	Director	10e. Street and Number	Arunder	10f	. Zip Code	Severna	Park	10g. Citizen o	F.What Cour	
	3a or	iQ I	831 Ritchie Hig	hway #407		- Др. о о о о	2117	6	regi onizon o	77 0	
	death	Funeral		2. Was Decedent Ever in	U.S. 13. Was D	ecedent of His	2114 panic Origin? (	Specify Yes or N rto Rican, etc.)	o- 14. Ra	ace - Americ	
9	after or ite ⊞ine		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		specity Cuban s 2 <b>∏</b> No	i, Mexican, Pue Specify:	rto Rican, etc.)		ack, White,	etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 28a-f show ont, the Medical Exaπiner must be notified at	d by	3 X Widowed 4 Divorced	Year or Dates:					Spec	Whi	te
	"nat	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's l	Jsual Occupat f work done du	tion uring most of wo	orking	16b. Kind of	Business/In	dustry
121	withii ene. than he Ma	m d m	Elementary/Secondary (0-12)	College (1-4or 5+)	_					D +1	•
d 21	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)		Transpo			VISOT ame (First, Middle		Railr	oad
a	should be ind Mental marked o	To B	Russell Payne				Kath	erine Co	untocc	,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exar⊓iner must be notified at once.		19a. Informant's Name/Relationship (Typ	e. Print) daughte	er 19b. Mailing Add	ress (Street ar	nd Number or F	Rural Route Num	ber, City or Town	n, State, Zip	Code)
	and 2 ealth n 27 I		Mrs. Elizabeth A. (	Clause /	306 Ch	alet Di					and 21108
altimore,	Pages 1 nent of Hu int: If iten		20a. Method of Disposition 1 XBunal 2 ☐ Cremation 3 ☐ Re		Place of Disposition ( cemetery, crematory	Name of or other place,	)	Date	20c. Location		
틸	. Pag tment tant: jury		4 Donation 5 Dother (Specify)		udon Park			29/2007	Baltim	ore,	Maryland
g	permit. Departr Importa any Inji		21. Signature of Funeral Service License	/		e and Address	_	2nd Ave			Burnie, MD
	40 2 4 0		23a. Part1. Exter the disease, or complic					1 & Crem		ervic	
			shock, or heart failure. List only one	e cause on each line.	ath. Do not enter the	mode or dying.	, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	CONGECTI.	VE HE	ART	TA	TUKF	2		
	Examiner			Due to ( <i>or a</i> s a conse	quence oi).						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	-					
	ocuted nd ransi	Examiner	triat illitiated events								
Ď,	e exe		resulting in death) Last	Due to (or as a conse-	quence of):			<del>- ·</del>			
08/60	ficate be executed physician and is the burial-transit	edical	d.								
	£ 50 %		IF FEMALE:	c. If yes, outcome pf pregr	nancy						
X Q Q	death certiff e attending ed for use as	cian	in the past 12 months?	1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	tal death 3□Ectop	ic pregnancy				ate of delive lonth	ery Day Year
5	that the de ed by the a detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		(Specify)					
ري ح	= 00 I	by P	Part II. Other significant conditions cont	ributing to death but not re	sulting in the underlying	ng cause given	ı in Part I.	23e. Did	tobacco use cor	ntribute to th	he cause of death?
Hecords	w requires been sign should be	ed be						1 🗆	Yes 2□ No	3 ☐ Prob	pably 4 Mnknown
ပ္သ		plet						24a. Was			psy findings available
	The ate his page	Completed						auto perf 1□ Yes	ormed?	death?	mpletion of cause of
N I I		Be (	25. Was case referred to medical examiner?					ath (Check only			
_	d dis	ျှ	1 ☐ Yes 2 ☐ No			DOA Other	4 □ Nursing I	Home 5□Res			у)
	Jing I	ion:	27. Manper of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe	how injury occu	rred	
ISION	Attending r death. ector: After by the funer	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At h	M nome farm street fac		es 2 No	28f Location	(Stroot and Num	har or Pure	al Route Number,
2	after after I Dire	Certification:	4 ☐ Homicide determined	building, etc. (Speci	ify)	iory, onico		City or To	wn, State)	iber or nura	i noule ivalliber,
	ospita hours ineral y filled	<u>a</u>	29a. Certifier 1 Certifying Physi	cian: To the best of my kn	owledge, death occur	red at the time	e, date and plac	e, and due to the	cause(s) and n	nanner as s	tated.
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examinone)	er: On the basis of examin and manner stated.	ation and/or investiga	tion, in my opi	nion, death occ	curred at the time	, date and place	e, and due to	the cause(s)
	To the company	Ž	29b. Signature and title of certifier	_		29c. License r	number		29d. Date sign	ed (Month,	Day, Year)
)			- meyon	n.	0		FZ14	1	Ode	ber:	24 2007
	10		30 Name and address of person who con	ole ed cause of death (Ite	m 23a) (Type, Print)	٥ الم	. DI	04. 0	v I N a a c	.445	170161
	Sta	to	31. Date filed (Month, Day, Yeār)	32. Régistrar's Sign	ature	OUT Y	c 71	en 1)	COLACIE	ANG	10101
	Registra		0000000	יחו	10 1	0					

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DHMH 17 Rev 1/2001

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Registrar

DHMH 17 Rev 1/2001

OCT 2 6 2007

			T For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	artment of H	ealth a	and Me	ental Hy	giene Reg. No	200	7	34408
			Decedent's Name (First, Middle	e, Last)						2. Date of De				3. Time of Death
в	Physic		EUGENE POSEY	ROLLINS						Month Octobe:	Da	200°		12:05 P M
	/Medi Examii		4a. Facility Name (If not institution	n, give street and numb	per)		4b. City, Town, or	Location of				. County of D		
	LAdiiii		Laurel Region	-	-	:	Laurel					ince (		ge's
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. la	st birthday)	If Under 1 Year	If Under		3. Date of Birt	th .	9	Birthplac	ce (State or Foreign
- 12	Director		234-12-6078	11 M 2□ F	87	Yrs.	Months Days	Hours	Min.	(Month, Da Jan • 1			Country est T	Virginia
	pu ,		Usual Residence of Decedent		10- Oit.	Taura sala								
	anyla shov dat	_	10a. State 10b. County			Town or Lo	cation						10d	. Inside City Limits
	he M 8a-f otifie	Scto		e George's	La	urel								1 □Yes 2□No
	with t	ä	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What	Country	?
	s 23s	Funeral Director	8807 Hunting			40.1	20708					USA		
	item item ner r	Ë	11. Marital Status 1 □ Never Married 2 □ Marr.	12. Was Decedor Armed Force ied 1X Yes 2	es?	. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Ori n, Mexicar	gin? (Spec 1, Puerto R	ity Yes or No- ican, etc.)		14. Race - A Black, W		
36	ırs afı I", or xaml	by	3K Widowed 4 Divorced	I If Yes Give			I□Yes 2X No	Specify:				Specify:	Whit	te
21215-0036	72 hours after death with the Maryland natural", or tems 23a or 28a-f show dical Examiner must be notified at	ed	15. Decedent	t's Education	T	16a. Deced	lent's Usual Occupa	ation			16b. K	ind of Busine		
15	nin 7% in "in Medik	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-4	or Eu	(Give life. L	kind of work done of OO NOT use retired	luring mos )	t of working	3			- Troide	,
212	d with giene ir tha the J	E	12th	Ø	.01 3+)	Cryp	tologist				А	ir For	ce	
b	othe	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (	First, Middle,	Maiden	Surname)		
Maryland	Aenta Aenta rked tic e	To	Hanley Bee Ro	llins				Marc	garet	Cook				
ary	short and N s ma	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Numbe	er, City o	or Town, Stat	e, Zip Co	ode)
	and 2 salth 127 i		Eugene Harold	Rollins/S	on	880	7 Hunting	Lane	e, #10	)l, Lau	ırel	, MD	2070	8
ore.	es 1 and of He rich		20a. Method of Disposition	0		ace of Dispo	sition (Name of natory or other place	e) :	Da	te	20c. Lo	ocation - City	or Town	, State
Ĕ	Pag nent int: If		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		ate		ndel Crem	' i	0/26	/2007	0de	nton,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	1	22	. Name and Addres	s of Facilit	y Doi	naldsor				P.A.
Ф	9 9 E E 8		- Janece	SIMO	<i>(</i> )м011	03 3	l3 Talbot	t Ave						•
1			23a. Part1 Ever the disease, or shock, wheart failure. List	complication that cau	sed the death.	Do not ente	er the mode of dying	g, such as	cardiac or	respiratory ar	rest,		A	pproximate terval Between
J	Physician		Immediate Cause (Final disease or condition	,	Sepsis								Ö	nset and Death
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100	B.\/ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a conseque	ence of):								
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_	leath certific attending p for use as t	Mec	IF FEMALE:											
Вох	ath co	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me pf pregnan h 2 □ Fetal o		Ectopic pregnancy					23d. Date of	,	V
	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	nt at time of dea n	ath 5□	Other (specify)					Month	Da	ay Year
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Š,	g be		Part II. Other significant condition	ins contributing to deat	a but not result	ing in the un	denying cause give	n in Part I,						cause of death?
orc	w requir been si should	ted	Hypernatremia							1 1	res 2	3	Probabl	ly 4 ∑Unknown
ec	e law has b je 2 sh	Completed by	Alzheimers	Dement	ia					24a. Was a		24b. Were	autopsy	findings available letion of cause of
H		8								perfor	rmed? 2.∏No	death	1?	□No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						of Death (	Check only o	ne)			
or Vital Records,	S S	2	1 ☐ Yes 2 ☐XNo	Hospital: 1 X Inp		R/Outpatient		4 LJ NU	rsing Home	e 5 ☐ Resid	ience	6 □Other (S	pecify)	
ū		ii o	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of l (Month,	Injury 2 <i>Day Year)</i>	28b. Time of Injury	28c. Injury Work			d. Describe h	ow injui	y occurred		
Division	atla at	Certification:	2 Accident Investig 3 Suicide 6 Could n	ation				'es 2 □ l						
Ξ	or Atten after death Director; in by the	ŧ	4 ☐ Homicide determi	nod 28e. Place of	injury - At hom , etc. <i>(Sp</i> ec <i>ify)</i>	ie, farm, stre	et, factory, office		28	f. Location (S City or Tow	Street an In, State	d Number or	Rural R	oute Number,
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 X Certifying (Check only one) 2 Medical €	<b>g Physician</b> : To the be <b>Examiner:</b> On the basi	s of examination	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date an pinion, dea	d place, ar th occurre	id due to the o d at the time, o	cause(s) date and	) and manner d place, and	as state due to th	ed. e cause(s)
	thin S	Med	29b. Signature and title of certifier	and manner	stated.		29c. License	number		,	20d Da	te signed (Me	anth Day	. Vand
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	H		30. Name and address of person v		,		<sup>rrint)</sup> Ituxent Pa	3 x lev. 7 0	т ш	00	Col	umbia,	MD	21044
	· Ct-	to	Chike Onwuka,  31. Date filed (Month, Day, Year)		istrar's Signatu		cusent Pa	ar Kwd	Y , # 2	.00,	COTI	minta,		21044
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ر مسر الم	Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)						2.	Date of D Month October	eath Day	Year		me of Death 900 hrs
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			4a. Facility Name (if not institution	n, give street and number	r)	41	o. City, Tow Glen Bu		cation of i	Deam			Anne Arui		
			Baltimore Washington		ge (In yrs. las	et hirthday)	If Under 1		If Under	24Hrs.	8. Date of	Birth (MI	M/DD/YYYY)	9. Birthplac	e (State or
	Funeral		5. Social Security Number				Months	Days	Hours	Min.	12	28	23	Foreign Country)	
	Director		035-16-8054	1X M 2 F	83	Yrs.					12	20			1112
	5		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on							1	Inside City Limits
	ow any		MD NA			Balti	more							1 2	Yes 2 No
	Aaryland 28a-f show 1 at once.	흸	10e. Street and Number				10f. Zip C					10g. C	citizen of Wha	t Country?	
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ď	n 72 h an "n	leted	Elementary/Secondary (0-12)			E.	pedi	tor	•			11	S. P	ostal	l Servic
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غِ	IMOFE, INID_Z 1 Z 15-10-30 Pages I and 2 should be filed within 72 hours al nent of Health and Mental Hygiene. Intent of Itealth and Mental Hygiene and item 27 is marked other than "natural or other traumatic event, the Me is al Examin or other traumatic event, the Me is all Examin	-	Helen P. Ric		ife					0 Te		ce,	Balt oc. Location -	imore	e, Md
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-	Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely	(Check only 1 Certifying one) 2 Medical E	xaminer: On the basis of	f examination	and/or investi	gation, in m	y opinic	n, death o	occurred	at the time	e, date a	nd place, and	due to the	cause(s)
	To t	Modical	29b. Signature and title of cer	and manifer su	ated				se numbe				29d. Date sig	gned (Mon	th, Day, Year)
		"	auet	- 1				0.0	.M.E.				October 2	27, 2007	
			30. Name and address of per		e of death (Ite	em 23a)				-					
10	Bund	1		ssistant Medical E		111 Penr	Street,	Baltim	nore, MI	D 2120	)1				
€2.		- 1	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month. Day, Year) 2007 32 Registrar's Signature												

ORIGINAL

OCME

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

felou, M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D.

OCT 2 6 2007

D0017695 October 24, 2007

CARROLL HOSPITAL CENTER, WESTMINSTER

Division or Vital Records, P.O. director, al or Attending F s after death. Il Director: After id in by the funera To the Hospital of within 24 hours at To the Funeral D

The law requires that the death certificate be executed

?7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

illed within 72 hours after

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State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6000



**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Ki 10 7007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹ M 2 □ F Director 216-58-2122 56 July 16, 1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD Baltimore Director Reisterstown 1 ☐ Yes 2☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-any Injury or other traumatic event, the Medical Examiner must be notify once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 Troubrook Court 21136 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 truck driver sanitation\_dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Rideout Dorothy Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4602 Waterfall Court #B Owings Mills, MD Pam Shorter/niece 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\\Other(Specify) in state 21. Sign tur of Euneral S. Ice Licensee Rade Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

Dise to (or as a consequence of): hoolve M. Nint **Physician** /Medical Due to (or as a consequence of) Examiner Vodvrd if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1∐ Yes 2 1 No Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ☐ ER/Outpatient ၉ 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 5 Pending Injury n 24 hours after death.

The Funeral Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the funct investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar 6

CON

31. Date filed (Month, Day, Year)

McLean

32. Registrar's Signature

MBOILAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltmare

2

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 10e, perFH, g872, 10/26/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 23 6:50 NATHAN RUBIN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner 4001 OLD COURT ROAD #213 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/10/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 AT **Funeral** 1 M 2□ F Months 89 135-18-2587 MI Director Usual Residence of Decedent 10a State 10c City Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? #213 4001 OLD COURT ROAD #231 Funeral U.S.A.

14. Race - American Indian,
Black, White, etc. 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Æes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER DEVELOPER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JACOB** RUBIN **ESTHER** WILENSKY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>EDA RUBIN / WIFE</u> <u> 4001 OLD COURT ROAD #213 - BALTIMORE, MD 21208</u> 20a. Method of Disposition 20b. Place of Disposition (Nam SHAARET TFIL'OH CONG. 1 X Burial 2 □ Cremation 3 □ Removal from State 10/25/2007 WOODLAWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Hote 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mejurer **Physician** disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 20 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 🗌 Yes 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Box 68760, P.O. I Division or Vital Records,

The law requires that the death certificate be executed

ral", or items 23a or 28a-f show Examiner must be notified at

"natural".

other traumatic event, the Medical

and Mental Hygiene.

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr any Injury or other traum

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burial-tran and

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29a, Certifier (Check only one)

certificate

72 hours after

3altimore, Maryland 21215-0036

Hospital or Attending Physician: To the Hospitar ... within 24 hours after death.

To the Funeral Director: After this c

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) C 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 6 Registrar

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			1- State of Maryland	-	artment of H			2007	31.1.11.
			Registrar  1. Decedent's Name (First, Middle, Last)		incate of i	Jean	2. Date of Death		3. Time of Death
	Physici /Medio		Margaret J. Smith				- A 1	Day Year Year	4:45 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number)		anne.	Location of Death		4c. County of Dea	
			5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Balton	
	Funeral Director		220-34.5160 10M 201F 71	Yrs.	Months Days	Hours Min.	Month, Day, Ye	136 ma	hplace (State or Foreign buntry) YULAND
pur	3		Usual Residence of Decedent  10a. State 10b. County 10c. City.	Town or Lo	cation				10d. Inside City Limits
Manyl	f sho	tor	md Carroll 1		minste	9			1 Yes 2 No
h the	r 28a	irec	10e. Street and Number	الحا	10f. Zip Code		10g.	Citizen of What Co	ountry?
uth wit	23a o	Funeral Director	2257 Carrollton Road	1	211	57		USF	f
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at ytattid 2.12.13-0030 should be filed within 72 hours after death with the Maryland	i result and welfare hyperial ryperial control or items 23a or 28a-f show titen 27 is marked other than "natural" or items or the marked other treumstic event, the Madical Examiner must be natified at	ρ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		I□Yes 2⊠No	Specify:		Specify:	hite
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2 shot	is mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a		al Route Num r, Cit		
and	sm 27		Linda H. Elseroad-daughter	22571	Carrollto		estminsk		21157
S & 7			1 → Burial 2 □ Cremation 3 □ Removal from State	ce of Dispo netery, cren	sition (Name of natory or other place	9) .		Location - City or	Town, State
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permit.	Impo any ir		Staci & mostini	E	Jans Fund	ral Cha	per + Cren d Parku	nation o	21234
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petno	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
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icate be e	physic s the b	dicai	d						
Centif	signed by the attending p d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of de	livery
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Lires t	signe d be c	d by	Part II. Other significant conditions contributing to death but not result			shin Panti.	1 Tes	_	the cause of death?  obably 4 2 Unknown
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clan:	ertifica ector.	Bec	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one)	140	20110
Physi	this c	P.	1 Yes 2 No Hospital: 1 Inpatient 2 E			4 M Norsing me	me 5 Residence		cify)
ding	or cours. rector: After this certilicate has by the funeral director, page	tion	27. Manner of Death  1	8b. Time of Injury	28c. Injury Work M 1 🗀	rat (? (es 2 \sum No	28d. Describe how in	njury occurred	
Atter	by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Street City or Town, St		ural Route Number,
itel o	rei Div		Danishing, etc. (appearly)						
Hosp 24 hol	Fune stely fi	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl (2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	and due to the cause red at the time, date :	e(s) and manner as and place, and due	stated. to the cause(s)
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funerei	Med	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Mont	h, Day, Year)
	/		Wind Kley mo		D31	19,-	18	125/07	
1	)		30. Name and address of person who completed cause of death (Item 2	3a) (Type, I	Print)		a &		
	Sta	to.	30. Name and address of person who completed cause of death (Item 2 Wandy Klors 2 0 701 N Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	to A	Suite 42	102 766	isa pud	21204	
	Registr		OCT 2 6 2007	1 Ast	13084.				

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State Registrar 0

Year)

31. Date filed (Month, Day,

32 Registrar's Signature

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Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: he law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 shruld be detached for use as the burial-transit

	Please Type or Print in Black In		-	·.
	1- State of Maryland / Dep Registrar  Ce	artment of Health and N ertificate of Death	// Mental Hygiene Reg. No. ↑ ↑	7 01116
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
ו ו	Charlotte Stoll		OCH V3 YOU	
•	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of E	eath
ę	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	batt more  If Under 1 Year   If Under 24 Hrs.	11/	
	1  M 2 F Vrs	Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country)
	214-38-2434 74 Usual Residence of Decedent		3/18/33	/irginia
	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
runeral Director	MD n/a Balti	more		1 Yes 2 No
Š	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
<u>5</u>	3111 Strickland Street	21229	USA	
5	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ■ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		merican Indian, Vhite, etc.
	3 Widowed 4 Divorced   If Yes, Give   Year or Dates:	1 ☐ Yes A No Specify:	Specify:	That is a
Completed by		edent's Usual Occupation	16b. Kind of Busine	White ess/Industry
DIG.	(Specify only highest grade completed) (Give life.	e kind of work done during most of work DO NOT use retired)	ang	
5		tress	Restaura	int
0	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden Surname)	
2	Claude Duane Flick  19a. Informant's Name/Relationship (Type. Print)  19b. Maili		Minetta Barkley	
		ing Address (Street and Number or Ru		
	Jacqueline D. Carter / Daughter 3111  20a. Method of Disposition		Baltimore, Mary Date 20c. Location - City	
	1 Burial 2 Moremation 3 Removal from State 4 Donation 5 Other (Specify) @ Loudon			e, Maryland
		2. Name and Address of Facility Lo		
		3620 Wilkens Ave.		
	23a. Part1. Enter tile disease, or condications that caused the death. Do not en shock, or heart failure. List or one cause on each line.			Approximate Interval Between
	Immediate Cause (Final disease or condition			Onset and Death
	resulting in death)  a. Due to (or as a consequence of):	C BONG COME	.ev	1 yew
	Sequentially list conditions b. Sequentially list conditions	mia		s DAUS
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):			6
		hstuctile Lun	disease	104-5
]	Due to (or as a consequence of):	)		
riiysiciali/Imedical E	d		<u>.</u>	_
	IF FEMALE: 23c. If yes, outcome pf pregnancy		201 0 111	
200	in the past 12 nonths?	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of Month	Day Year
33	1 Yes 2 No 4 Pregnant at time or death 51 9 Unknown			
	Part II. Other significant conditions contributing to death but not resulting in the L		23e. Did tobacco use contribut	e to the cause of death?
2	typertension Dioheres melling	الا	1 Yes 2 No 3	Probably 4 Unknown
	Commany cutery diseur	re	24a. Was an 24b. Wer	e autopsy findings available
completed by			autopsy prior performed? deat	to completion of cause of h?
U	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	165 213-110
2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	ome 5 ☐ Residence 6 ☐ Other (	Specify)
=	27. Mannes of Death  1 Deatural 5 Pending (Month, Day Year)  28b. Time of (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how injury occurred	
Sati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
cei IIII calloll.	4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
	20a Cartifica	Ab a constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant in the constant		
	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dear  (Check only  2 Medical Examiner: On the basis of examination and/or in	in occurred at the time, date and place	, and due to the cause(s) and manne	r as stated.
2		rivestigation, in my opinion, death occu	rred at the time, date and place, and	due to the cause(s)
Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (M	

State Registrar

31. Date filed (Month, Day, Year)

2 6 2007

32. Registrar's Signature portes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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maiden choice

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CONSUIR

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	_1	State Registrar		Cei	rtificate of	Death		No.2 11	7 3441
ysicia		1. Decedent's Name (First, Middle, Las					2. Date of Death Month October	25,2007	3. Time of Death ear 4:58 A
/ledica amine	-	Gladys Eil  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	OC CODET	4c. County of	
aiiiiie		Stella Maris	,		Casey			Balt	imore
eral ctor		219-12-3304	ex	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 16,	1920 <sup>9</sup>	Birthplace (State or Foreig Country) Maryland
	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limi
led	į	MD Baltimore	_	Timor	nium				1 ∐Yes 2 🔀 N
non a	Director	10e. Street and Number		- 1 2 11101	10f. Zip Code		10g.	. Citizen of Wha	at Country?
5	<u>a</u>	2549 Barrison	Point Road		21221			USA	
5	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
	و آ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1		1 □ Yes 2 ☑ No	Specify:		Specify:	White
i  :		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	16	 b. Kind of Busir	ness/Industry
1	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of work d)	king		
			4	Homer	naker			Own Hon	ne
5 A	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Mai	iden Surname)	
nanc	၉ _	Roland Trott  19a. Informant's Name/Relationship (7)	Time Print)	10b Mailie	na Address (Street	Gladys	ral Route Number, C	ity or Town St	ata Zin Cada)
trau		Janet Hartlove (			,		Rd. Essex,		-, -,,
James	-	20a. Method of Disposition			osition (Name of matory or other place				ty or Town, State
5		1 X Burial 2 □ Cremation 3 □	Hemoval from State		_				
<u> </u>	1	4 □ Donation 5 □ Other (Specify	111411	anda (	Cemetery	ıntingto			
any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	100		2. Name and Addre	1 1			al Home, Inc
8 0	1	xuplan O	سعي				uson, Mary		
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	. Do not em	ter the mode of dyli	ng, such as cardiac	or respiratory arrest	1	Approximate Interval Between Onset and Death
ian cal		disease or condition resulting in death)	a. <b>DEMENTIA</b>						
ner			Due to (or as a consequent	ence or):					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):					
- langing	<b>C</b>	cause. Enter Underlying Cause (Disease or injury) that initiated events	C.						
<u> </u>	ш	resulting in death) Last	Due to (or as a consequent	ence of):					
	Physician/Medical		d						
	Med	IF FEMALE:					7.	1	
n nasaga	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	⊒Ectopic pregnanc	y		23d. Date of Month	
ا فا	Sici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath 5	Other (specify)			World	l Day Teal
	F.	Part II. Other significant conditions or	ontributing to death but not resul	Iting in the u	nderlying cause giv	ren in Part I	23e Did tobar	co use contrib	ute to the cause of death?
	2	Tartii. Othor Significant Solidations of	ontributing to doubt but not room	ing in the G	macriying oadse giv	TOTAL TOTAL T			☐ Probably 4 Unknow
onone :	Completed						1		
D U	E D						24a. Was an autopsy performe	l pri	ere autopsy findings availat or to completion of cause o ath?
		OF Was seen at the T					1  Yes 2	No 1 E	Yes 2□No
, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐ E	D/Outrot:	ot 3 DOA Oth		th (Check only one)	- A**	(O#A TOCK-C-
rector		1 ☐ Yes 2 X No	i 🗆 iripatierit 2 🗆 E	ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE					
al director	P	27. Manner of Death		28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred					
al director	P	1 Natural 5 ☐ Pending	(Month, Day Year)			rk?  Yes 2∐No		,,	1
al director	၉	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury me, farm, str	M 1□			et and Number	or Rural Route Number,

Registrar DHMH 17 Rev 1/2001

State

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

OCT 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. egistrar's Signature
7

29c. License number

3725

TIMONIUM, MD 21093

10/25/07

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Carolyn Catherine Schmitt Oct. 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 08-01-1925 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 82 Director 219-16-2575 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pots Springs Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick James Eva Sody ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23, Rick Schmitt/Son PA 4664 Glenville Road, Glen Rock. 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State OCTOBER 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10-25-2007 Baltimore, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road. Towson. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ CAROLYN SCHMITT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide

Рм

Year

29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

29b. Signature and title of certi

31. Date filed (Month, Day,

DR. TARIQ MAHMOOD

Medical

2300 DULANEY VALLEY RD.

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

			For State Registrar	State of I	Marylan	-		nt of H te of L		nd M		giene Reg. No	000	7 011	1.0
	Physicia	an	1. Decedent's Name (First, Middle, La.	,							2. Date of De Month	ath Day	y Year	3. Time of Dea	ath 9
	/Medio		4a. Facility Name (If not institution, giv	Mary Fran		mith	4b. City	, Town, or	Location of		Octobe		. 2007 County of Dea	8:15AM	141
	LAdilli	CI	11001 Hunt		,			R	lockvi	11e			Mont	gomery	
	Funeral Director		5. Social Security Number 6. S			last birthday) Yrs.	If Unde Months	er 1 Year	If Under 24	4 Hrs. Min.	8. Date of Bir (Month, Da January	y, Year)	9. Bi	thplace (State or Foountry)  New York	reign
	pu ,		Usual Residence of Decedent  10a, State 10b, County			y, Town or Loc	nation				ourium y	10,	721	10d. Inside City Li	1
	laryla shov	'n			100.01	y, rown or Loc	Janori							1 ☐ Yes 2 5	
	the N 28a-f notifie	Director	Maryland Mont  10e. Street and Number	gomery			10f 7	Ro	ckvil	le_		10a Cit	izen of What C	^	nx.
	3a or		11001 Hunt	owar Driz	7.0		100.2		20852			.09. 0		d States	
	death ms 2	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13. V	Vas Dec			n? (Spe	cify Yes or No Rican, etc.)	)-	14. Race · Am	erican Indian,	
336	d within 72 hours after death with the Maryland sien. Jene. Than: "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2[ If Yes, Give Year or Date	Mo	i		2XX No	Specify:	Pueno i	nican, etc.)		Black, Wh	White	
215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced			ation during most o	of workin	201	16b. K	ind of Business		
7	ithin 7 ne. " nan "r	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. E	OO NOT	use retired	)	SI WOIKII	ig		_	e Stamp	
2	led w lygier her th	ပ္ပ	12					Secre		a Nama	/Final bandulin			nufacture	er
Maryland	l be findal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal Hedontal	Be	17. Father's Name (First, Middle, Last,						18. Mothers	s Name	(First, Middle		ŕ		
ž	hould d Me mark matic	၉	Stephen 19a. Informant's Name/Relationship (	Francis Type Print)	Finne		a Addres	ss (Street :	and Number	or Rura			DeLea or Town, State,	Zin Code)	
Z Z	nd 2 s lith ar 27 is rtrau		Clifford E. Smi	**	and									and 20852	,
ō,	s 1 ar if Hea item other	i	20a. Method of Disposition		20h F	Place of Dispos	sition /N	ame of		D	ate		ocation - City o		
Ê	Page nent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ate C	emetery, crem Monts remato	gome:	ry • Inc		Octo	ober 2007	Ве	thesda.	Mary1and	1
Baltimore,	permit. Pages 1 and 2 should be filed will be partment of Health and Mental Hygien Important: if item 27 is marked other th any Injury or other traumatic event, the once.		21. Signature of Funeral Service Licer	1500	M0033	22 I	Name a	and Addres	ss of Facility	Rob	ert A. O West	Pum Mon	phrey E tgomery	uneral Ho Avenue	me/
k!		Н	23a. Part1. Enter the disease, or com-	plications that cau	sed the deat								0.5	Approximate	
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Coloni	c Fist	tula, I	nfec	ted						Interval Betwee Onset and Deal 2 Weeks	
	Examiner			Due to (or Crohn	as a conseq									20 77	
7		er	Sequentially list conditions,	D	as a consed									20 Years	
7.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0											
ρ	e exec an an irial-tr		resulting in death) Last	Due to (or	as a conseq	uence of):									
8/60,2	ficate be executed physician and s the burial-transit	dical		⊾d											
	sertific ding p	/Mec	IF FEMALE:	23c. If yes, outcor	ma of proces	2007			***********						
X R R	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	n 2∐Feta	al death 3 🗔	Ectopic Other (	pregnancy					23d. Date of de Month	elivery Day Year	r
j.	the d y the iched	nysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□Unknowr		Journ Old	Other (								
S, T	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions	ontributing to death	h but not res	ulting in the un	derlying	cause give	en in Part I.		23e. Did 1	tobacco i	use contribute	to the cause of death	h?
ğ	quire en sig uld bu	d be	Lewy Body Dementi	a							10	Yes 2	K∐ No 3□F	Probably 4 □Unkr	nown
ပ္ပ	law re as bee 2 sho	Completed	<u>/</u>								24a. Was	an	24b. Were a	utopsy findings avai	ilable
_	The ate h	E O									perfo	ormed? 2 💢 No	death?	s 2 No	e 01
VItal	siclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only				
5	physic this c	은	1  Yes 2 No	Hospital: 1 Inpa		ER/Outpatien	t 3 🗆 🖸		4 🗀 Nurs				6 □Other (Sp	ecify)	
ב	iding Physician: th. : After this certifica ? funeral director, p	ion	27. Manner of Death 1 X Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	М	28c. Injury Work	/at ⟨? Yes 2 □ No		28d. Describe	how inju	ry occurred		
ISION	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be		iniury - At he	ome, farm, stre					P8f Location /	Street ar	nd Number or F	Rural Route Number,	
Ž	al or A s after al Dire	Certification:	4 ☐ Homicide determined	building,	, etc. (Specil	<i>y</i> )		.,,			City or To	wn, State	e)	raidi Frodic Hamber,	,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical (	29a. Certifier (Check only one) 1 X Certifying Pt 2	nysician: To the be niner: On the basis and manner	s of examina	owledge, death ation and/or inv	occurre estigatio	ed at the tin on, in my o	ne, date and pinion, death	place, a	and due to the ed at the time,	cause(s , date an	) and manner a d place, and de	as stated. le to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier	100-			2	9c. License	number			29d. Da	te signed (Mor	th, Day, Year)	
)			> MANNEN	13F				D3797	5			Oc	toher 3	22, 2007	
	0		30. Name and address of person who												
الموال	10		Jeffrey P. Indris	ano, M.D.	. 1080	1 Lock	dood	Driv	e, #28	80,	Silver	Spr	ing, MI	20901	
	Sta Registr		31. Date filed (Month, Day, Year)	07	istrar's Signa مرکزن	Nue Assa	ener	,							

DHMH 17 Rev 1/2001

			For State Registrer	asc i	State of		d / Depa		of H	ealth a					34420
	Physicia /Medic	in al	Decedent's Name (First, Mid JEWEL     A. Facility Name (If not institute)	L E				4b City	Fown or	Location o	of Death	2. Date of De Month OCT . 2	3, <sup>Da</sup>	Year	3. Time of Death 12:30 P M
	Examin Funeral		Genesis Herit  5. Social Security Number	age 6. Sex	Nursing	Home  Age (In yrs.	last birthday)	,	da1k			8. Date of Bii (Month, Da March		Baltim	ore hplace (State or Foreign
ţx.	Director		215-12-1347  Usual Residence of Decedent  10a. State 10b. Coun	ty	]M 2∏F	85	Yrs. ty, Town or Lo	cation				March	18,	1922	N. C.
	h the Man or 28a-f sh	irector	Md .	N/A	,		Balti	more	Code				_	tizen of What Co	•
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny figury or other traumatic event, the Mayleal Examinar must be multied at once.	Funeral Director	313 S. Macon  11. Marital Status  1 Never Married 2 M		12. Was Decede Armed Force 1 Tes 2. If Yes, Give	şş?	i	Was Deced If Yes, spec				ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
21215-0036	hin 72 hours and "natural", on "natural", on "Maules Exp	Completed by	3X Widowed 4 ☐ Divorc  15. Deced (Specify only high Elementary/Secondary (0-12	ent's Eductions grade	Year or Date		16a. Dece (Give life.				t of worki	ng		(ind of Business	/Industry
	d be filed witi antal Hygiene ced other the	Be	8TH  17. Father's Name (First, Middle Alex Cook		Ď		Ti	n Sor	ter			(First, Middle		hlehem	Steel
Maryland	and 2 shout th and Me 27 Is mark r traumati	<u>۲</u>	19a. Informant's Name/Relatio				19b. Mailii 1312	ng Address C Sc	(Street a	and Numbe	Dr.,	Bel A	er, City	or Town, State, . Marylan	Zip Code) d 21015
Baltimore,	Pages 1 au nent of Hee ant: If item ury or otha		20a. Method of Disposition X Burial 2 Crematio 4 Donation 5 Other	n 3 □R (Specify)	lemoval from St	ate 20b. F	Place of Disponentery, created Holly H	nsition (Name matory or o	ne of ther place emet	ery 1		5/07		ocation - City or Ltimore,	Town, State Maryland
Balt	permit. Departr Importu eny Inj		21. Signature of Fulleral Service	res			6		aste	rn Av	ve.,	Baltim	ore,	Zeiler & Maryla	
	Physician /Medical		23a. Part 1 Enter the disease, shook, or heart failure. L ummediate Cause (Final disease or condition resulting in death)	or compli ist only or	Due to (or	A A CONSEC	2 / A	RIE	Ry	g, such as	SE/	43E	arrest,		Approximate Interval Between Onset and Death
760,	e be executed ysicien and burial-transit	cai Examiner	Sayuratiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or Due to (or	as a consec	217 quence of):								
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and a page 2 should be detached for use as the buriar-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		h 2∏Feta nt at time of o	al death 3[	⊒Ectopic pr □ Other (sp						23d. Date of de Month	livery Day Year
٥	quires that t n signed by uld be deta	by	Part II. Other significant cond	itions cor	ntributing to dea	th but not re	sulting in the u	inderlying c	ause giv	en in Part I	l.		tobacco Yes 2		o the cause of death?
Il Records,	The law recolote has bee page 2 short	Completed		4						-		24a. Wa auto per 1 🗆 Yes	s an opsy formed? 2 N	prior to death?	utopsy findings available completion of cause of s 2 1 No
of Vita	Physician: The this certificeteral director, pag	To Be	25. Was case referred to med examiner? 1 Yes 2 No		Hospital: 1 □ In		ER/Outpatie		70000	er: 4 N	ursing Ho		sidence	6 □Other (Spe	ecify)
Division of Vital	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifico completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Cou	ding stigation ld not be ermined	28a. Date of (Month) 28e. Place of	f Injury - At h	28b. Time of Injury	М		yat k? Yes 2□		28d. Describe 28f. Location City or To	(Street a	and Number or F	iural Route Number,
ā	fospital or thous after uneral Director of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	edical Cert	29a. Certifier 1 Certific (Check only 2 Medic	ying Phy	sician: To the b		owledge, dea					and due to the	e cause(	s) and manner a	is stated.
	To the by within 2. To the F complete	Medi	29b. Signature and title of cent		and manne		MU			2 7/	, 88	>		Pate signed (Mon	
	3		30. Mame and address of pers  Q V Q Q Q  31. Date filed (Month, Day, Ye	110	ompleted cause	of death (Ite	Max	Print)	P	lac	e b	run	da	lic M	) 21222
	Sta Registi		OCT 2 6			الوات د الداد	e dos	and I							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan		artment of H rtificate of L		nd Mental		2007	34421
	Physici	an.	Decedent's Name (First, Middle, La.	_					2. Date Monti		Day Yea	3. Time of Death
	/Medic		Furm		chul	7			octo		19,200	
1	Examir	er	4a. Facility Name (If not institution, give			i dan	4b. City, Town, or				4c. County of De	
	<del>, , , , , , , , , , , , , , , , , , , </del>			11ey Assis		- INIVIO	If Under 1 Year	We Sh	1 7 1	4 Dieth		Birthplace (State or Foreign
	Funeral Director			ØX / 2□F / A	де ( <i>in yr</i> s. 86	last birthddy) Yrs.	Months Days	Hours	Min. (Mont	of Birth h, Day, Ye 27, 1	ar) 9.0	Country) .ryland
			Usual Residence of Decedent		00				NOV	2/, 1	1920 110	Tyrana
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	B-f st	iç	MD Howard			Elli	cott City	,				1 ☐ Yes 2 ☐ No
	or 28	ire	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	Country?
	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "netural", or Itams 23a or 28a-f show event, the Medical Exam actimistics indifficulat	Funeral Director	3341 Coventry Co	urt Drive			210	142			USA	
	r deg	ne	11. Marital Status	12. Was Decedent Armed Forces		.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes Puerto Rican, etc	or No- :.)	14. Race - Al Black, W	merican Indian, hite, etc.
36	or li	ру F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give	No		1 ☐ Yes 2🌠 No	Specify:			Specify: V	hite
Ö	hour tural	p p	15. Decedent's E	Year or Dates:		162 Dogg	dent's Usual Occupa	ation		166	. Kind of Busine	es/lodueto/
15	in 72 "ne" i	lete	(Specify only highest gra	de completed)		(Give	kind of work done of DO NOT use retired	during most	of working	100	, Killa of Dasille	samuati y
12	filed within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	se1	f employe	ed		to	ool & di	le company
b	Hygie other ent,	0	17. Father's Name (First, Middle, Last,						's Name (First, M			
<u>a</u>	should be ind Mental Indexed o	To B	Leo Schultz					E1s	sie Roman	ı		
Maryland 21215-0036	\$ 5 E E		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Street a	and Number	r or Rural Route N	lumber, Cit	ty or Town, State	e, Zip Code)
	N -		Patricia Kulacki/	daughter		2217	Cherokee	e Driv	ve Westmi	.nste1	r, MD 21	.157
Ore	gas 1 and t of Healt if item 2 or other	- 33	20a. Method of Disposition 1  Burial 2  Cremation 3	Domoval from State	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other plac	e)	Date	20c	. Location - City	or Town, State
Ĕ	Pagas ment of h ant: If ite ury or of		`4 XDonation 5 ☐ Other (Specif		Ho	ward U	ni Medica	1 S¢h	10/24/	07 Wa	shingto	n, DC 20001
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer Ronald S	Wale, Dir	ector		Name and Address tate Ana	•		W. 1	Baltimor	e Street
			23a. Part1. Enter the disease, or com	difference that cause	d the deat		Baltimore			on, arrest		Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.			110 - 0				Interval Between Onset and Death
	Pnysician /Medical	i i	disease or condition resulting in death)	a			estive	Tar	Failur			Days
	Examiner			Due to (or as	s a conseq	uence or):						·
	Y	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a conseq	uence of):			_			
	outad nd ransit	Examiner	that initiated events	C.								
o,	en ar urial-t	EX	resulting in death) Last	Due to (or as	s a conseq	uence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	lical		d								
9	eath certifica attending pt I for use as ti	Med	IF FEMALE:									
Вож	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3[	Ectopic pregnancy				23d. Date of Month	delivery Day Year
<u>o</u> .	at the de by the a tached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of d	eath 5	Other (specify)					
<u>α</u>	that t		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying cause givi	en in Part I.	23в.	Did tobacc	co use contribute	to the cause of death?
Records,	uires sign Id be	d by								1 🗀 Yes	2 □ 10 3 □	Probably 4 Unknown
CO	w requir been s should	lete							24a.	Was an	24b. Were	autopsy findings available
Re	The lav	Completed								autopsy performed	prior death	to completion of cause of
Vital		Ö	25. Was case referred to medical					26 Place	of Death (Check		No 1□Y	65 2 10
$\leq$	Physicien: this certificantal director,	To B	examiner? 1  Yes 2 No	Hospital: 1 Inpati	ient 2 🗆	ER/Outpatier	nt 3 DOA Oth	or /	sing Home 5		e 6 □Other (S	pecify)
n of	ding Ph h. After th funeral		27. Man or of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury a <i>y Year)</i>	28b. Time of	f 28c. Injun Worl	y at k?	28d. Desc	ribe how i	njury occurred	
<u>i</u>	Attending in death. ector: After by the fune.	atic	2 Accident investigation	1				Yes 2□N	No			
Division	F 6 F C	Certification:	3 Suicide 6 Could not b	286. Place of Ir	ijury - At ho tc. (Specif	ome, farm, str y)	eet, factory, office			ion (Street or Town, St		Rural Route Number,
Ų	Hospital		29a. Certifier 1 ☑ Certifying Ph	ysician: To the best	t of my kno	wledge, deat	h occurred at the tin	ne, date and	d place, and due t	o the cause	e(s) and manner	as stated.
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 Medicel Exar	niner: On the basis of and manner s	of examina	tion and/or in	vestigation, in my o	pinion, deat	h occurred at the	time, date	and place, and	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	21/1/10/1	11.0		29c. License				Date signed (Me	
•				MOGISE	1111		100	085999	73	00	ctoper	22,2007
			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print) P. Suite	307	westm	hile	MO	21157
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	iture	20 a	′ (	4, 3,			
	Registr	ar	OCT 2 6 2007	A GAS	and and	of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	Land					

Steven Albert Sauer	1- For State Registrar	ate of Maryland		tment of ificate of		nd Mental		leg. No. 20	07	3442
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Steven Albe	,,					2. Date of Dea Month October 1			me of Death 005 hrs
(	4a. Facility Name (if not institution 3901 Washington Blv		er)	4	b. City, Town, o			4c. County of I Baltimore		
Funeral Director	5. Social Security Number 220–50–0751	6. Sex 7.	Age (In yrs. las		If Under 1 Ye Months Da			rth(MM/DD/YYYY) 5	9. Birthplac oreign Country)	
	Usual Residence of Decedent	I Z M Z F		Yrs			12,0 7 -	., -, ,		
ow any	10a. State 10b. County  MD Balt	imore		own or Locati Lansdow					Ī	Inside City Limits Yes 2 X No
the Maryland tor 28a-f shelffed at once	10e. Street and Number				10f. Zip Code			10g. Citizen of What		
1 the M 3a or 2 otified	3901 Washing	gton Blvd			2	1227		US	SA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		arried 12. Was Decede Armed Force 1 X Yes		If Y		n, Mexican, Pu	? ( Specify Yes or Nuerto Rican, etc.)	o- 14. Race - White, o	etc.	ndian, Black,
ours aft	15. Decedent's Education (Spe	or Dates:	completed)	16a. Deceden	t's Usual Occup	ation (Give kind		16b. Kind of Busin		ry
36 uin 72 houn han "natu dical Exan	Elementary/Secondary (0-12)	College (1-4)	or 5+)	•	isabled		,	none		
215-0036 efiled within 7 lal Hygiene than nt, the Medica	17. Father's Name (First, Middle		L		unk	18.Mother's N	Name (First, Middle,		<del></del>	unk
MD 2121 d 2 should be fi d a should be fi n 27 is marked umatic event,	19a. Informant's Name/Relations Albert Sauer/ Bro	ther		8016 L	Address, (Street LA Penn St	et and Numbe Mirrells reet Ba	rorRuralRoute Nu S <b>Inlet</b> , SC 11timore,	mber City or Town, 29576 MD 2120	State, Zip	Code)
ore, Nes I and of Health	20a. Method of Disposition  1 Burial 2 X Cremation	n 3 Removal from			ition (Name of c		Date	20c. Location - C		
altimore, mit. Pages I ar partment of He, uportant: If ite	4 Donation 5 X Other S		Crematory	ss of Facility	10/31/2007	Peltsvill	e. MD			
Bal perm Depa Impo	21. Sign lare of Funer Sprice Runal d	ara 655 ₩ 1201 Towa	reen Pasture son. MD 2128	<del>Pe''St</del> 6	reet					
Physician /Medical xaminer	23a. Part I. Enter the disease of fature. List only one cause Immediat. Lause (Final disease	on each line.							Ap	proximate Interval etween Onset and Death
Q.	or condition resulting in death)  Sequentially list conditions,	Due to (or as a co	nsequence of):	•						
niner	If any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of):	:					0	
executed an and al - transit ical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
od sici be	UNPENDED	X AMENDED , 2	20a-c,22,	perFH.G	372, 10/3	1/07 TT				
Records, P.O. Box 6876C The law requires that the death certificate icate has been signed by the attending physpage 2 should be detached for use as the bCompleted by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes, out Live birth	come of pregnant tat time of dear	ancy 2 Fe	tal death 3 her (Specify)		regnancy	23d. Date of d Month	elivery Day	Year
O. B nat the de de de by the etached the etached the etached the y Phy	Part II. Other significant condi			sulting in the u	inderlying cause	given in Part I	I. 23e. Did	tobacco use contrib	ute to the c	ause of death?
b, P.C irres that a signed d be deta	Atherosclerotic cardi	ovascular disease					1Y			4 Unknown
of Vital Records, P.O. ig Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach n: To Be Completed by P						-		opsy pri		r findings available etion of cause of
ician: 'icertific certific ector, I	25. Was case referred to medica examiner?	Hospital:				oe of Death (Cl			, _	
n of Vi ing Physi After this funeral dir	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of	Injury :	ER/Outpatient 28b. Time of I	tun	jury at Work?	lursing Home 5 28d. Describe	Residence 6 🗸		ne
on c ending sath. or: Af or: Af the fun	1 Natural 5 Pen 2 Accident Inve	ding ding stigation	ay,Year)		1 Yes 2 No					
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Finneral Director: After this certificantlelety filled in by the funeral director. edical Certification: To Be (	3 Suicide 6 Cou		of Injury - At hor	me, farm, stre	et, factory, office	building, etc.	28f. Location or Town,	(Street and Number State)	or Rural R	oute Number, City
To the Hosp within 24 hos To the Fune completely fi	29a. Certifier 1 Certifying P	hysician: To the best o	examination and							use(s)
To wit To con	29b. Signature and title of certifi	and manner state er	ed.		29c. Lice	nse number		29d. Date signed	(Month, E	Day, Year)
	for	yes m	0_		0.0	C.M.E.		October 20,	2007	
541)	30. Name and address of person Tasha Greenberg MD				Penn Street	t, Baltimore	, MD 21201			
State Registrar	31. Date filed (Month, Day, Year)		strar's Signatur	e Asset		-	<u></u>	-		

OCME

			1 - For Amend #10e pEr	State of Marylan	d / Depa	rtment of F	Health and N	<i>l</i> lental Hygie	ne		
		-	Registrar  1. Decedent's Name (First, Middle, Las		Cer	tificate of	Death	Reg.	No. 2007	34423	
	Physicia		PATRICIA	4	TAY	102		Month	Day 4 Year 2007	10: 47 AM	
Sec.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	(,,[		r Location of Death	OCTORE	4c. County of Death		
	<u> </u>	н		PKINS HOSP			ORE C	ITY	N.	A	
b	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)	
ŭ.	Director		Usual Residence of Decedent	~ 2	/ 110.			APRIL 26	1756 MA	RYLAND	
	yland how at	l.	10a. State 10b. County	10c. City	, Town or Loc	cation		~		10d. Inside City Limits	
	ne Ma Ba-f s	Director	MARYLAND 1	J/A		BA	LTIMOR		Y	1 XYes 2 □ No	
	with the a or 2 be no		10e. Street and Number 330 MK	onlight Cour	t	10f. Zip Code	2,01	10g	Citizen of What Cou	ntry?	
	after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. W	Vas Decedent of H	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri		
٥	after or ite		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, White	etc.	
2000	ural",	d by	3 Widowed 4 Divorced	Year or Dates:				140	Specify: BZ	ACK	
7	in 72 l	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedi (Give F life. D	ent's Usual Occup kind of work done OO NOT use retire	during most of work d)	king	b. Kind of Business/Ir	ndustry	
7	d with giene. ir thar the N	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	5	UPER	VISOR		DMV		
<u> </u>	al Hyg	Be C	17. Father's Name (First, Middle, Last)	* 4		1	18. Mother's Nam	ne (First, Middle, Mai	iden Surname)		
) Ja	ould t	2	KISDON	MCCLE.		/	MAR	VA	VAUG	HN	
M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7)	LOR (HUSBAND	19b. Mailing	g Address (Street		0 0 10	ity or Town, State, Zi		
ก	s 1 an f Heal ttem 2 other		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other pla		C1, BAL Date 200	c. Location - City or T	0. 21225 Town, State	
Ē	Pages nent of int: If It		1 Bunal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	DAR		<i>-</i>	31-07 6	BALTIMO	RE MA	
Dallimo	permit. Departn Importa any inju		21. Signature of Funeral/Service Licens	see	22,	Name and Addre		BROWN	JR, FUNE	RAL HOME	
Ω	20 <b>= 20</b>		AM	HUNS	Ö	2140 1	N. FULT	ON AVE.	BALTO.		
			23a. Part1. Enter the disease, or comp shock, or beart failure. List only of mmediate eause (Final					or respiratory arrest		Approximate Interval Between Onset and Death	
•	Physician /Medical		disease or condition resulting in death)	a. WARICE  Due to (or as a consequ		BLEED	51106			3 DAYS	
	Examiner			· CIRRHOSIS							
	p .⊭	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							3 YEARS	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. HEPAI	1715					do 1 ETTICS	
0/00,	icate be executed physician and s the burial-transit	al E		2	201100 017.						
00	tificate g physas the	ledical		d							
Š	th cert endin	an/N	23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1□Live birth 2□Feta		Ectopic pregnanc	v		23d. Date of deliv	,	
	e dea the att	Physician/Me	in the past 12 mmths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify) _	,		Month	Day Year	
ŗ	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death but not resu	ılting in the un	derlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?	
ecords,	quires n sign ald be	d by			-			1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown	
ָבָ ט	aw rec s bee 2 shou	Completed						24a. Was an	24b. Were aut	opsy findings available	
ב	The late happage 2	omi						autopsy performe 1∐ Yes 2 <b>X</b>	d? death? INo 1 □ Yes	ompletion of cause of 2□No	
N I G	cian: ertifica	Be C	25. Was case referred to medical examiner?	11. 2-1		l au		th (Check only one)			
5	Physi this cral dire	₽:	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatient 28b. Time of	3 DOA		ome 5 Residence	ce 6 ☐Other (Spec	ify)	
5	th. : After fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju Wor M 1 □	rk?  Yes 2 □ No	200. Describe now	injury occurred		
VISIOII	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	1	me, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,	
5	ital or rs afte ral Dir led in	Cert									
	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical		ysician: To the best of my kno liner: On the basis of examina and manner stated.							
	o the	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licens	se number	29d	. Date signed (Month	, Day, Year)	
)	->F0		Samin Zuba	in /MEDICAL	DOCT	on RE	5-000	00	TOBER.	24 2007	
	4		30. Name and address of person who o	completed cause of death (Item		Print)	- 000	01 711 -		2120	
			SANIA ZUBAIR 31. Date filed (Month, Day, Year)	32. Registrar's Signa	101+1	= 51K	ttl, B	HLIMOR	E, MD	2128+	
	Sta	ite	51. Date liled (World, Day, Teal)	oz. riegistiai s signa	Man All	9					

DHMH 17 Rev 1/2001

		For State Registrar	State of Ma	•	epartment of Certificate of		Mental Hygie Reg.		7 3442
		Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
Physici /Medic		LOUISE R	ANDALL TAT	ľΕ			October	Day Ye 25 2007	M
Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Deat		4c. County of E	
	,	GILCREST NURSING			TOWSON				MORE CO
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)
Director		212-36-4419 Usual Residence of Decedent		66			OCT. 12	1941	MARYLAND
nyland how	L	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
e Ma Ba-f s	Director	MARYLAND N/A			BALTIMORE				1 XYes 2 No
vith th		10e. Street and Number			10f. Zip Code		10g.	Citizen of What	Country?
s 23a	Funeral	925 N. FULTON	AVE 1st F1			1217		U.S.A.	American Indian,
fter de r item	Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?		13. Was Decedent of If Yes, specify Cui	ban, Mexican, Puer	to Rican, etc.)		Vhite, etc.
urs al al", ol Exam	ρ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify: E	BLACK
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's E	ducation ade completed)	16a.	Decedent's Usual Occu (Give kind of work done		rkina 1	b. Kind of Busine	ess/Industry
vithin ne. han " e Med	du.	Elementary/Secondary (0-12)	College (1-4or 5+	)	life. DO NOT use retire	ed)			
filed v Hygie ther t		.0th grade   17. Father's Name (First, Middle, Last	)		PATIENT CA		ne (First, Middle, Mai		D CENTER
d be fental	o Be	ALEXANDER RAND					'N SAWYER	den odmane,	
shoul ind M i marl	၉	19a. Informant's Name/Relationship (		19b.	Mailing Address (Stree			ity or Town, Stat	te, Zip Code)
and 2 alth a 27 Is		Kevin Tate/Son		92	25_N. Fulto	n Ave., B	altimore.	Marvlan	d 21217
es 1 a of He of He filtem		20a. Method of Disposition  XXX Burial 2 □ Cremation 3 □	Demouslifes Chats	20b. Place of	Disposition (Name of y, crematory or other pla	i		c. Location - City	
Pages ment of I ant: If Ite ury or o		4 □ Donation 5 □ Other (Special		MT ZIC	ON CEMTERY	10-3	1-07 L	ANSDOWNE	, MARYLAND
permit. Departr Imports any Inju		21 Singuistre of Fundral Service Live	yor/		22. Name and Addr WILLIAM C	ess of Facility BROWN CO	MMUNITY FU		
gorag		Julian G	/>		1206 W NO	RTH AVENU	E		
		23a, Part1. Enter the disease, or conshock, or heart failure. List only Impediate Cause (Final	one cause on each line	ne death. Do n	ot enter the mode of dy	ring, such s cardia	or respiratory arrest		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (ex eq	me	nene y	7 300	1		weeks
Examiner			Due to (or as	consequence	cherol	VASC	ular de	serse	year
	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	f):				
xecuted and Il-transit	xamine	Cause (Disease or injury that initiated events resulting in death) Last	c						
	ш	resulting in death) cast	Due to (or as a	consequence of	if):				
ficate be ex physician s the burial	dical		d						
leath certific attending p	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	f pregnancy				23d. Date of	deliven
death atter	iciar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		Month	Day Year
t the by the ached	hys	9 Unknown	9□Unknown						
w requires that the de been signed by the should be detached	Δ.	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause gi	iven in Part I.	23e. Did tobac	co use contribut	e to the cause of death?
equire en siç ould b	ed	Strokes,					1 ☐ Yes	2 No 3 □	Probably 4 Unknown
law ras be	Completed by						24a. Was an autopsy		e autopsy findings available to completion of cause of
sician: The lav certificate has rector, page 2	Com						performe	d2 deat No 1 □	h? `
cran: certific ector,	Be	25. Was case referred to medical examiner?	Magnital				ath_(Check only one)		
Physical this call direction	2	1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient  28a. Date of Injury		patient 3 DOA		lome 5 Residenc		Specify) (+05p10
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buriar	tion	1 Natural 5 ☐ Pending	(Month, Day		ijury Wo	ork? □Yes 2□No	28d. Describe how	injury occurred	,
Atten deatl octor:	fical	3 Suicide 6 Could not b		y - At home, far	m, street, factory, office		28f. Location (Stree	et and Number o	r Rural Route Number,
al or after	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)			City or Town, S	State)	
Hospital 24 hours Funeral tely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge	death occurred at the	time, date and place	e, and due to the caus	se(s) and manne	r as stated.
To the He within 24 To the Fu	ledical	one)	and manner state	ed.					
0 = 0 =	Σ	29b. Signature and title of certifier	1		29c. Licen	ise number	29d.	Date signed (M	lonth, Day, Year)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) OCT 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 / A / ( ) & & MC 6701 N. Churles St. Backs. Md 2. 23 & 32. Togistrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)
Coofober 25, 2002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21, 2007 7:20 PM October Xinh Long Tran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Hospice Casey House Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F May 11, 1946 Vietnam 214-45-7707 61 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Montgomery Boyds 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or r must be r 21825 Seneca Ayr Drive 20841 United States Funeral r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 12 Elementary/Secondary (0-12) Carpenter Furniture f Health and Mental Hygier Item 27 is marked other th other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nen Long Tran ဥ Tram Anh Nguyen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr 21825 Seneca Ayr Drive, Boyds, Maryland 20841 Suong N. Tran / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 24, 2007 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. Myelettes M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Septicemia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1☐ Yes 2☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:  $4\square$  Nursing Home  $5\square$  Residence  $6 \times O$ ther (Specify) $\times Hospice$ 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide .ດ 24 hou. the Funeral Dir 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou

To the Fune
completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and medical examiner stated.

0 State

31. Date filed (Month, Day, Year) OCT 2 6 2007 Registrar

29b. Signature and title of certifier

are

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0064615

29d. Date signed (Month, Day, Year)

October 22, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) October 22 Stephen **Physician** 830 PM Watson 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore HUSPITAL Ine Johns HOPKINS n/a If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F 10/21/2007 Director MD none Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State r 28a-f show notified at 1X Yes 2 □ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number pe a 3010 Bero Road 21227 r items 23a iner must b United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. "natural", or iten edical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen Richard White Dominique Alexus Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Dominique Watson/mother 3010 Bero Road, Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any Injury or o 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 10.30.07 | Baltimore, MD Donati**∂**n 5 ☐ Other (*Specify*) 21. Si Funeral Service Li An Ae 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Balto., MD 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 hours Pulmmary Hypoplasia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of)! Examiner 40 hours Renal agenesis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed and that initiated event resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. After (Month, Day Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) RES - 000 october 22,2007 satpute 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Baltimore street Monique 600 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 2 6 2007

07-08168	
Roger D. Ward	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Roger D. Ward		- For State	State 0	i waryianu i		tificate of		and Ment	arriygi		g. No.	200	7 3442
Physician	1 Personal Programme (1 most, mindule) and (1							ate of Death	n Day	Year	3. Time of Death 0841 hrs		
Medical Examine r <sup>™</sup>	Roger Date Mara							October 20, 2				ounty of Death	
	7311 Contee Road  Laurel  Prince George's								's				
Funeral	7	5. Social Security Number	6. Sex	7. Ag	e (In yrs. la	st birthday)	If Under 1 \	Year If Under	Min.			Foreign	
Director	L	215-66-2350		1 2 F	51	Yrs.	I Monard	,,,,,		June 1	3, 19	956 Co.	intry)₩V
any		Usual Residence of Deceden 10a. State 10b. Cour			10c. City,	Town or Locati	on						10d. Inside City Limits
and show	5	MD Pri	nce G	eorge	Lau	rel							1 X Yes 2 No
th the Maryland 23a or 28a-f sh	25	10e. Street and Number		-			10f. Zip Cod				•	of What Coun	try?
ith the 123 o		7311 Contee		12, Was Decedent	Ever in U.S	S. 13. Wa	2070	Hispanic Orig	in? ( Specify		U.S. I		can Indian, Black,
leath w	. I	1 X Never Married 2	Married	Armed Forces?				ban, Mexican,				White, etc.	
ral", or	Š.			Yes, Give Year or Dates:				No specify:		, -		ec <i>ify</i> : Whit	
2 hours	eg -	15. Decedent's Education (: Elementary/Secondary (0-		College (1-4 or		16a. Deceden during me		life. DO NOT			160. Kind	of Business/li	idustry
036 ithin 7; rne. r than	Completed	10		• (		Drywal	l Fini	sher /				structi	on
15-0 filed w Hygic d othe		17. Father's Name (First, Mic							,	st, Middle, M			
212. uld be Menta marke c event	0 00	Millard Clin 19a. Informant's Name/Relati				19b. Mailing	Address (S			ginia I Route Num	_	or Town, State	Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If file an 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Rose M. Ward	/fri	end								nd 2070	
Sre, an of Heal of Heal If iten		20a. Method of Disposition  1 Burial 2 X Crema	tion 3	Removal from St		Place of Dispos crematory or other		f cemetery,	Da	ate	20c. Loc	ation - City or	Town, State
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Bal permi Depar Impo injur		21. Signifure of Funeral San	MA.	s <del>e</del>	M007	73 31	naldso 3 Talb	ress of Facility on Fune: oott Av	ral Ho e. Lau	ome, Purel.	A. Marv	land 20	707-4389
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/Medical Examiner		Immediate Cause (Final dise or condition resulting in deat	ase a	Ethanol an			oxicatio	n					Death
		Sequentially list conditions,	·/ b	ue to (or as a cons	equence or	.). 							
	ig	if any, leading to immediate cause. Enter Underlying Ca	ise .	ue to (or as a cons	equence of	f):							
. 0 .	Examiner	(Disease or injury that initiate events resulting in death) La		ue to (or as a cons	equence of	f):			<u> </u>		_		
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transin		LINDENDED	d	AMENDED									<del>                                     </del>
60, ate be e hysicial	Medical	IF FEMALE:		#23a . 27 . 2 23c. If yes, outcome			72, 10/ <u>3</u>	0/07 TT			23d. E	Date of deliver	,
687 certifica iding p		23b. Was decedent pregnant past 12 months?	in the	1 Live birth Pregnant at		2 Fe	tal death	3 Ectopic	pregnancy		Me	onth [	Day Year
Box 687  The death certific the attending properties as the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second control of the second	Physician/	1 Yes 2 No 9	Unknown	9 Unknown	time of de	5 Ot	her (Specify)						^
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S, P quires t										24a. Was a			topsy findings available
COTC law rechas be	Completed	<del></del>								autop perfor	sy rmed?	prior to death?	completion of cause of
TRe		25. Was case referred to me	dical				26.P	Place of Death	(Check only	1 Yes :	2 No	1 🗸 Ye	es 2 No
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ing Ph	<u>.</u>	27. Manner of Death  1 Natural 5		28a. Date of Inji (Month, Day,	ury Year)	28b. Time of I	njury 28c.	Injury at Work	1	d. Describe h	how injury	occurred	
Sior Attend r death ector: by the	g [	2 Accident	Pending nvestigation	Fnd 10/2		Fnd 7:0		Yes 2 X		unk f. Location (S	Street and	Number or Ru	ıral Route Number, City
Divi	Certification:		Could not be letermined	(Specify) for			or, ractory, and		73	or Town, S	State)	Laurel	
		29a. Certifier (Check only 1 Certifying	g Physicia	n: To the best of m	y knowled	ge, death occur	red at the tim	e, date and pla	ace, and due	e to the caus	e(s) and r	manner as stat	ed.
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		Patr	1	= - F	200	. J		.C.M.E.				er 21, 200	
n-	-	30. Name and address of pe	son who co	ompleted cause of	death (Item	23a)					<u> </u>		
-6		Patricia Aronica-Po					111 Penr	Street, Ba	altimore,	MD 2120	1		
Sta Registr	_	31. Date filed (Month, Day,Y		37 Registra	E	ire Appea	K)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 34428 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Alice E. Walker Oct.24,2007 10:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5700 Hamilton Avenue Baltimore Rosedale 8. Date of Birth (Month, Day, Year) April 1 2,1936 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 1 □ M 2 □ MF 220-64-4424 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show MD 1 ☐ Yes 2 ☑ No Baltimore Rosedale Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5700 Hamilton Avenue 21237 USA Funeral "natural", or items : 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: White 3 Widowed 4 ☐ Divorced Completed r than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond William Walker Helen V. Duvall ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Waterbury /daughter Department of Health Important: If Item 27 any Injury or other tr once, 27 5700 Hamilton Avenue Balto. MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Cemetery 10/26/07 Baltimore MD 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave.Balto. MD Colo 8 Connelly Funeral Home of Essex 21221 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Marina /Medical Due to (or as a consequence of): **Examiner** Due to (or is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical SS attending p for use as IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 1□ Yes 2D No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA ours after death.
neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) 70 t 31. Date filed (Month egistrar's Signature Pay, Year) 32 State 6 200 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M  1- State Parietrar  Certificate of Death		ene g. No.20	07	34429				
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	9.110.		3. Time of Death				
	Physicia		Edgar Raymond Wenk, Jr.	October	18, 20	Year 007	1:15 AM				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County						
	Examin		5414 Highridge Street Baltimore		Ва	ltim	ore				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign				
	Director		215-24-9648 1XM 2□F 79 Yrs. Months Days Hours Min.	11/12/2	7		yland				
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			———T	10d. Inside City Limits				
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	death with the Maryland rme 23a or 28a-1 ehow r must be notified at	ect	Md Baltimore Baltimore  10e. Street and Number 10f. Zip Code	10	g. Citizen of	What Cou	ntrv?				
	with De L	ā	01007		•		,				
	leath	era	5414 Highridge Street   21227	ecify Yes or No-	USA 14. Rad	e - Ameri	can Indian,				
0	ritter	Funeral Director	1 Never Married 2 Married 1 Never 2 No	Rican, etc.)		ck, White,	etc.				
2-003p	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1946-53		Specif	V: W	hite				
ה ה	72 hg	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)		6b. Kind of B	usiness/In	dustry				
Z	Athin ne.	idi	Elementary/Secondary (0-12) College (1-4or 5+)		1.14	arr of	Baltimore				
70	iled v tygiel her ti nt, in		8 0 Chauffer  17. Father's Name (First, Middle, Last) 18. Mother's Name				Baltimore				
au	ntal h	Be .				,					
ج	hould d Me mark matic	၉	19a. Informant's Name/Relationship (Type, Print)  19b. Malling Address (Street and Number or Rura	Marie St		. State, Zi	p Code)				
Z Z	Ith ar		Mrs. Mary R. Wenk / Wife 5414 Highridge Street	Baltimo	ore. Ma	arv1a	nd 21227				
ore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural; or iteme 23a or 28a-1 show important: If them 27 is marked other than "natural; or iteme 23a or 28a-1 show eny injury or other traumatic event, tra Medical Examinar must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location						
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Š S	certif oding ise as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Da	ate of deliv	verv				
gox	death e etten ed for u	Physician/M	200. Was decembed pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month			Day Year				
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 T	requires thet the een signed by th hould be deteche	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	23e. Did tobacco use contribute to the cause of dea						
Vital Records,	quire en sig uld b			1 ☐ Ye	s 2□No	3 ☐ Pro	bably 4 Unknown				
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<u> </u>	Attending r death. actor: After by the fune	cati	2 Accident investigation M 1 Yes 2 No	201 1		<b>.</b>	10-11				
DIVISION	or At	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	City or Town		Der or Hui	ral Route Number,				
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	Hos 24 hc Fun etely	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one)  and manuar stated.								
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After completely filled in by the funeral	Me	20b. Signature and title of certifier.	29	9d. Date signe	ed (Month	, Day, Year)				
	, > P 0		DO061040		10/19	1200	7				
0	TI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0 09:3	2.					
ı			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  To be filed (Month Court Port)	-are M	V UL	-11					
	Sta		31. Date filed (Wichiti, Day, Fear)								
	Registi	rar	OCT 2 6 200/ Parks 15								

07-08108 Roslyn West

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

tosiyn West	1- For State	epartment of Health and Mental Hy Ce <i>rtificate of Death</i>	Reg. No. 200	7 3443
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 17, 2007	3. Time of Death 2245 hrs
Medical Examiner	Roslyn A. West  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
,	St Agnes Hospital	Baltimore		
Funeral	5. Social Security Number 6. Sex 7. Age (In y	/rs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreig	n
Director	214-54-4757 1 M 2×F	57 Yrs.   World   Buys   No. 1	06/21/1950 Co.	untryMaryland
any	Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Location		10d. Inside City Limits
	MD	Baltimore		1 X Yes 2 No
Maryland 28a-f show d at once. rector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cour	ntry?
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once. ted by Funeral Director	633 Braeside Road  11. Marital Status	in U.S. 13. Was Decedent of Hispanic Origin? ( S	USA Decify Ves or No. 14 Race - Ameri	can Indian, Black,
eath wi items ust be uner	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2	If Yes, specify Cuban, Mexican, Puerto		,,
s after de ral", or niner m	3 Widowed 4 Divorced If Yes 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2	1 Yes 2 No specify:		lack
hours nature	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12) College (1-4 or 5+)	d) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. Kind of Business/lired)	Industry
5-0036 ed within 72 hour lygiene. other than "nature Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	Mayor's Office	City of B	altimore
5-00 led wit Hygien other Con	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maiden Surname)	
121 Id be fil fental I narked event,	Brunes West 19a. Informant's Name/Relationship (Type, Print)	Lilli 19b. Mailing Address (Street and Number or	e Waters Rural Route Number, City or Town, State	a. Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	Damita White / Daughter	633 Braeside Road Bal		- 1
re, N 1 and Health fitem er trau	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	4 Donation 5 Other Specify:	Loudon Park Cemetery 10/	/24/07 Baltimore,	Maryland_
Balt Depart Import	21. Signature of Funeral Service Licenses		oudon Park Funeral Baltimore, Marylar	
Physician	23a. Part I Enter the disease or complications that caused he c	death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Medical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Athero	osclerotic Cardiovascular Disease		Death
Adminer	or condition resulting in death)  Due to (or as a consequent	nce of):		
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	nce of):		
	(Disease or injury that initiated events resulting in death) Last	nce of):		
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	d			
60, ate be ex hysician e burial	UNPENDED		23d. Date of deliver	TV.
1876 rtificati ing phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live birth	2 Fetal death 3 Ectopic pregr		Day Year
Box 687 e death certifics the attending p ed for use as th	1 Yes 2 No 9 V Unknown g Unknown	of death 5 Other (Specify)		
O. B at the d tached		not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
ires that signed a be det.		stage renal disease	1 ✓ Yes 2 No 3 Pro	
(ecords, The law require are has been signage 2 should be				utopsy findings available completion of cause of
Rec The la ficate h		26.Place of Death (Chec	1 🗸 Yes 2 No 1 🗸 Y	
ital sician: s certif	examiner?   Hospital:		ing Home 5 Residence 6 Othe	er:
of Vi	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ion ttendir leath. tor: A	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
Division of Vital Records, P.O. Spital or Attending Physician: The law requires that th hours after death.  Brail Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	3 Suicide 6 Could not be determined (Specify)	<ul> <li>At home, farm, street, factory, office building, etc.</li> </ul>	28f. Location (Street and Number or R or Town, State)	Rural Route Number, City
in the boundary		owledge, death occurred at the time, date and place, ar	.! nd due to the cause(s) and manner as sta	ated.
To the He within 24 To the Fu completely	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or investigation, in my opinion, death occurred	i at the time, date and place, and due to t	the cause(s)
F × F ö	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mi	
	alien 2			
3	30. Name and address of person who completed cause of death Zabiullah Ali, M.D. Assistant Medical Exam		1201	
	31. Date filed (Month, Day, Year) 32 Registrar's S	Signature	OCME	
Registra	DCT 2 6 2007	Sed Fig.	UUME	

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AMEND TITEM 9, 10a-f, 16a b 10a-20c, 22 per FH, C873, 11, 8 (07 WS)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 OCTOBER **Physician** 200 4:30 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAT CENTER Mulare 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1∏M 2□F Months Days Hours 383-58-9047 Director 55 Mar 21, 1952 Michigan Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20-4 any linury or other traumatic event, the Martin-1 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits -unk unk Yes 2□No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 218 W. Monument Street, Apt. A-1 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? U.S. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unk 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ŭnk Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No white þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction unk unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be မ iling Address (Street and Number or Rural Route Number City or Town, State, Zip Code)

W. Monnest Street, Apt. A-1, Baltimore, MD 21202

St. Paul Place Baltimore, MD 21202 19a. Informant's Name/Relationship (Type. Print)

Gree Smith - friend

Mercy Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 11/8/07 Baltimore, MD Metro Crematory, Inc. of Facilitation Society of Maryland, Inc. 21. Signature of Fundamental Survice Licensee Director inderick Brid Baltimore, MD 21228 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMBOLIC STROKS O days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Endo carde Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the aid be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed' 2 🗆 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Ne 1- Inpatient 2 □ ER/Outpatient 3 □ DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 □ Matural 5 ☐ Pending investigation within 24 hours are: \_\_\_\_ To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hileudeus address of person who con who completed cause of death (Item 23a) (Type, Print) Baltinere MD 301 81. 31. Date filed (Month, Day, Year) OCT 2 6 2 32. Registrar's Signature State 2007 Registrar

as in per me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Marylan		tificate of L		/IEntal Hy	Reg. No. 2	2007			
Physic	ian	1. Decedent's Name (First, Middle, Last)							Year	3. Time of De 12:05 A		
/Med		Daniel	Aboud		4b. City, Town, or	Location of Death	10/9/20		ounty of Death			
Exami	ner	4a. Facility Name (If not institution, give so Suburban Hospital	street and number)	Bethe			ntgome					
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl	h v Year)	9. Birth	pplace (State or Fo Intry) Wash DC	oreign		
Director		5/9-56-5232	<sup>1</sup> Mi 2□ F 65	Yrs.	Months Days	Hours Will.	Sept 6,	1942		Wash DC		
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loc	cation			<u> </u>		10d. Inside City L	_imits	
Maryla f sho	j	100 Mantagan	ery Ro	ckvill	.e					14 Yes 2[	□No	
r 28a- notif	irect	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Co	untry?		
th with 23a o	Funeral Director	6105 Montrose Road	i		20852			Unite	d Stat	es		
ems er mu	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)		. Race - Ame Black, White	e, etc.		
s afte	bv Ft		1  Yes 2 XNo If Yes, Give Year or Dates:	1	∐Yes 2XINo	Specify:		Sį	pecify: Whi	te.		
<b>DEBILLIMOFCE, INTERFYIGHTIC ALLES-DUUJO</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	ed b		cation	16a. Deced	lent's Usual Occup	ation		16b. Kind	of Business/	ndustry		
hin 72 nn "ns Medic	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	during most of work l)	king		_			
d with	Į,	12		Wato	h Maker				welry			
Viano  Suld be file  Mental Hy  arked oth  attic even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Wilma Ru						
yla ould J Mer narke	P	Nessim Aboud  19a. Informant's Name/Relationship (Ty	enc. Print)	10h Mailin	q Address (Street					(in Code)		
Mal Id 2 sl Ith an Ith an Ith an Ith an	1			1	Fallsta			-				
Heal Heal tem 2		20a. Method of Disposition	Brother 20b. F		sition (Name of natory or other place		Date		tion - City or			
Pages ent of nt: If I		1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State M1	t. Leba	anon Ceme	rery 10/1	12/07	Adolr	shi Ma	rvland		
<b>Salitimor</b> Dermit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licens	oe	£.c	Name and Address	ss of Facility	al Direc	ction,	Inc.	il y land		
<b>a</b> a a a a a		) de		10	91 Rocky	ille Pike	e. Rocky	ille,			52	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									en ath	
Physician		Immediate Cause (Final disease or condition resulting in death)  Cardiomyopathy  a. Cardiomyopathy								3 Months	3	
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
2.5	٠.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					-					
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	cause. Enter Underlying Cause (Disease or injury									
exectan an and rial-tra	EX.	resulting in death) Last										
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artificating pheas the	Med	IF FEMALE:	20 - 1/						TIE -			
death cer death cer e attendir	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d. Date of delivery Month Day			ar	
the de	Veig	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	Jean JL								
ords, P.C requires that the een signed by the			significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribu							the cause of dea	ith?	
Hecords, he law requires t has been signe ge 2 should be c	by by						1 🗆	Yes 2	No 3□Pi	obably 4 □Uni	known	
eco law re as bee 2 sho	plate						24a. Was		24b. Were at	utopsy findings ava	ailable	
The lav	Completed						perfe	ormed? 2 A No	death?	2 □ No		
VITAL IN SICIAN: The certificate rector, pag	Ro	25. Was case referred to medical			l au	26. Place of Dea	th Check onl	one			_	
di is	F	1 ☐ Yes 2 XNo	Hospital: 1 X Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o		4 🗀 Nursing Fi	ome 5 Res			cify)		
Ing Ing	į	27. Manner of Death  1 XNatural 5 Pending investigation	(Month, Day Year)	Injury	Wor	yai k? Yes 2∐No	250. Describe	now injury	occurred			
DIVISION I or Attending after death. Director: After	ficat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At h	ome, farm, str			28f. Location	Street and	Number or R	ural Route Numbe	9r,	
affer affer din b	Cortification.	4 ☐ Homicide determined	building, etc. (Special	fy)			City or To	wn, State)				
DINISIO Pe Hospital or Attend n 24 hours after death. The Funeral Director: /			rsician: To the best of my kno iner: On the basis of examina	owledge, deat	h occurred at the ti	me, date and place	e, and due to the	cause(s) a	ind manner a	s stated. e to the cause(s)		
To the Hosp within 24 ho To the Fune completely f	Modical	one)	and manner stated.					_				
Vit To	2		-		29c. Licens		~ ~		_	th, Day, Year)		
9		Helinatio		T 230) (Tuno		0660	05	octo	ber	4,200	+-	
		30. Name and address of person who o	ompleted cause of death (Iter	getown	Road, Be	ethesda,	Marylan	d 20	814			
S	tate	31. Date filed (Month, Day, Year)	32 egistrar's Sign									
Regis	tra	OCT 1 2 20	32 egistrar's Sign	U M								

State of Maryland / Department of Health and Mental Hygiene 007 34433 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13ª **Physician** Month 2007 6:45 P M Robert B. Adair /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Oeath 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth 9/8/1938 Birthplace (State or Foreign Country)

PA **Funeral** Months Days Hours Min. 197-30-0157 69 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 North Pintail Drive 21811 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 10 Yes 2 □ No 1960 If Yes, Give Year or Dates: 1987 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married / 13 / 200 プ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1987 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cellege (1-4or 5+) Col. Retired Army U.S. Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin F. Adair Anna R. Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 North Pintail Dr.,Berlin, MD 21811 Mary C. Adair DOB OS DOD 10 Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 12/20/2007 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a rart. Enter the inserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart have. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 2 1 No Division of Vital After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 4 Inpatient 12 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident completely filled in by the Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53612 Vhursician person who completed se of death (Item 23a) (Type, Print) Heathway Dr Berlin MD 21811 ET 15+1 Andrea 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 5 2007 Registrar

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Holair

robert B.

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Intollie Nasii Ada		State Registrar	te of Maryland / Depa Cer	tificate o			пат ну	-	g. No.		)440
Physicia ledical Examin	7	1. Decedent's Name (First, Middle, Antione Nasir						2. Date of Deat Month August 21		3. Time o	
		4a. Facility Name (if not institution, Holy Cross Hospital	give street and number)			own, or Location	of Death		4c. County of I		
Funeral Director		214 72 0122	Sex 7. Age (In yrs. Ia 2 yea		Months		er 24Hrs. s Min.	-	h(MM/DD/YYYY) 5 3/2005	9. Birthplace (St Foreign Country) MI	
nd show any ce.	٠	Usual Residence of Decedent  10a. State 10b. County  MD Howar		Town or Local	tion						de City Limits
the Maryland as or 28a-f show tifted at once.	Director	10e. Street and Number 5172 Brookway	Apt 4		10f. Zip 210				og. Citizen of What USA	Country?	
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5-0036 ed within 72 hour lygiene. other than "natu	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5+)	None	nost of wor	Occupation (Give king life, DO NOT	T use retir	ed) -	16b. Kind of Busin		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, La Bryan Antione						(First, Middle, N Anita	Maiden Surname) Webb		
and 2 should leath and Me tem 27 is mar traumatic ev		19a. Informant's Name/Relationship Shade			-				nber, City or Town, mbia MD		
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other Uniquity or other transmatic event, the Mac		20a. Method of Disposition  1 XBurial 2 Cremation  4 Donation 5 Other Spec	3 Removal from State		sition (Nam	ne of cemetery,		Date	20c. Location - C 7 Colum	ity or Town, Sta	te
Balti permit. Departn Import	ľ	21. Signature of Funeral Service Li	censee	Di	ınn&	Address of Facili	35	Eads S	t. NE W	20019 ashinc	iton Do
Physician /Medical xaminer		23a. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	a. Sudden unex laine	Do not enter ted death	the mode o	of dying, such as	cardiac or	respiratory arre	est, shock, or heart	Approxi Betwee	imate Interval en Onset and Death
	_	Sequentially list conditions,	b.  Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence			100					
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760, cate be execut physician and the burial - tra	Medical	X UNPENDED	X AMENDEDa, 27, 28a-f	, perME,	G873,	11/14/07	TT				
Box 6876 he death certificate the attending phy hed for use as the l	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcome of preg  1 Live birth 4 Pregnant at time of de	nancy 2 Fe	etal death ther (Spec	3 Ectop	ic pregnal	ncy	23d. Date of de Month	elivery Day	Year
ires that the disagned by the	2	Part II. Other significant condition		esulting in the	underlying	cause given in P	Part I.		obacco use contribu		
cords law requires been bas been 2 should	Completed							24a. Was autop perfor	rmed? de	ere autopsy find or to completion ath?  Yes	
Vital Recession: The his certificate director, page	8	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien		OA Other			Residence 6	Other:	
n of \\ ling Plıy After th funeral	<u>0</u>	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		28c. Injury at Wor	rk?	28d. Describe i	now injury occurred	]	
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director: Completely filled in by the	ertification:	2 Accident Suicide Homicide Pendin Investig	gation 28e. Place of Injury - At he			1 Yes 2 X			Street and Number state)		
To the Hospital within 24 hours To the Funeral completely filled	۱ د	29a. Certifier 1 Certifying Phys	sician: To the best of my knowled ner:On the basis of examination a	ge, death occu				due to the caus	e(s) and manner a	s stated.	
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.			. License numbe			29d. Date signed		
		Donna muli		23.0\		O.C.M.E.			August 22, 2	:007	
		30. Name and address of person w Donna M. Vincenti, MD	ho completed cause of death (Item Assistant Medical Exan		1 Penn	Street, Baltim	nore, MI	D 21201			
Sta	te	31. Date filed (Month Pay, Year)	2007 32. Régistrar's Signatu	H Ro	2000 1	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MFVD#4aperMD10/12/07, BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Beatrice Muriel **BEHRENS** October 0 2007 /Medical 10. 4a. Facility Name**lvibeuty**n, gi**Assastad**ber)**Living** 8919 Liberty Lane 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac **MOntgomery** 8. Date of Birth March 15, 1913 New York If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 057-01-5446 94 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at Director MD Montgomery 1 ☐ Yes 2v☐ No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re 8919 Liberty Lane 20854 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of the filed with and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: Specify Completed by Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Trenk Rose Taffet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Behrens 4420 W. Random Rock Pl., Marana, Arizona 20b. Place of Disposition (Name of cometery, crematory or other place)
Mt. Hebron Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.12,2007 Flushing, New York 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee 254 Carroll St. N.W., Washington, D.C. 23a. Part1. Enter the disease, or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cross on each line. Immediate Cause (Final Acute Bloodloss Anemia due to **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleeding Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Unknown Etiology and burial-trar Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Endstop Dementia 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Seizure Disorder 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) <del>Assisted Livina</del> Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours a

> State Registrar

Susan J. Miller, MD, 31. Date filed (Month, Day, Year) OCT 12 2007

29b. Signature and little of certifie

6844 Tulip Hill Terrace, Bethesda, MD 20815 **∰**gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D35579

29d. Date signed (Month, Day, Year)

October 10, 2007

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	Physici			A1ma	,		Buskirk		Month 10	Day 15	Year 07	1919 M	
,	/Medio		4a. Facility Name (If not in		street and number)			or Location of Death		4c. County of Death			
	÷.		WMHS Brad	dock Ca	ımpus		Cumbe:	rland		Allegany			
F	uneral		5. Social Security Number		7. Age	(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	av. Year)	Col	nplace (State or Foreign untry)	
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land	at ow			County		10c. City, Town or	Location					10d. Inside City Limits	
Man	a-f sh	ķ	Maryland	Allegar	ny	Frostburg						1 X Yes 2 □ No	
th the	or 28; e not	Director	10e. Street and Number	52 W. M	echanic Street		10f. Zip Code			10g. Citizen o	What Co	untry?	
ath wi	23a ust b	ral					21532-			U.S.A.			
er de	items ner m	Funeral	11. Marital Status	- Ted 64	12. Was Decedent E Armed Forces?	ver in U.S. 1	<ol> <li>Was Decedent of F if Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	o-   14. Ra   BI	ace - Amer ack, White	rican Indian, o, etc.	
So aft	il", or xami	by F	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ E		1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 💆 No	Specify:		Spec	ify: Wh	nite	
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d be file	even	Be	17. Father's Name ( <i>First</i> , Vincent Gall					18. Mother's Nam  Katie Pre		, Maiden Surna	ime)		
aryiario 21213-0030 should be filed within 72 hours after death with the Maryland	mark	P	19a. Informant's Name/R		ivne Print)	19h M:	ailing Address (Street			ner City or Tow	n State 7	in Code)	
and 2 s	27 is		Wanda Smith		daughte		Warn's Lane		stburg	_	ryland	21532-	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	item othe		20a. Method of Dispositio	n			sposition (Name of rematory or other pla		Date	20c. Location	- City or	Town, State	
mit. Pages	int: If		1 ☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐ 0	mation 3 ∐I Other ( <i>Specify</i> )	Removal from State		nd Crematory	1	ober 17, 200	7 Cumber	land M	faryland	
Dall permit.	Department or neath and wenter righter.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral	Service Licens	n)unix	_	22. Name and Addre	ess of Facility eral Home, 57	Frost Ave	Frostbu	g. MD	21532	
81			23a, Part1, Enter the dis	ease, or comp	lications that caused	the death. Do not					<i>B</i> ,	Approximate	
Phy	/sician		Immediate Cause (Final disease or condition	are. Listonly c	RUPTU		BDOMINA	L ADR	TIC A	VEURU	cus	Interval Between Onset and Death	
/N	ledical		resulting in death)		a	consequence of):	pport/lark	0 7.0 1	(10 /11			HOUR	
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Z F	endin r use	Physician/M	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, outcome p		3 □Ectopic pregnanc	v			ate of deli	•	
e deat	he att	sicia	in the past 12 montl 1 ☐ Yes 2 ☐ No	hs?	4□Pregnant at		5 Other (specify)			"	/lonth	Day Year	
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Of VILAI DECOLOS, F.O. BOX 60/00, Physician: The law requires that the death certificate be executed	signe d be c	l by	rait ii. Other aiginicant	Conditions	intributing to death bu	thotresulting in the	s underlying cause gri	reiriir Fait I.		Yes 2		obably 4 Dunknown	
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ıysici	iis cer direct	o Be	examiner? 1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatier	nt 2 R/Outpat	ient 3 DOA Oth	ner:		idence 6 □0	ther (Spec	cify)	
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tendii O	the fu	catic	2 Accident	investigation Could not be			M 1 □	Yes 2 No					
To the Hospital or Attending	when it is not a state beau.  To the Funcatal Director, After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide	determined	28e. Place of injuition building, etc.	ry - At home, farm, . (Specify)	street, factory, office		28f. Location City or To	(Street and Nur wn, State)	nber or Ru	ıral Route Number,	
ospita	uneral uneral		29a. Certifier 1	Certifying Phy	rsician: To the best o iner: On the basis of	f my knowledge, de	eath occurred at the ti	me, date and place	, and due to the	cause(s) and i	manner as	stated.	
the H	the F	Medical	one)		and manner stat	ed.			Tred at the time				
To		2	29b. Signature and title of	or certifier		nm	29c. Licens			29d. Date sign	· ·		
	2		20 North	um	rum	マ) / / / V		25406		CTOB	FK	16,2007	
	MN			erson who c	MD 900	Seton i	Drive Cur	nberland	d Man	land o	2150	12	
	Sta Registr		31. Date filed (Month, Da	1 7 200	34 Registra	r's Signature	soule						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** DOROTHY 10 CLAIRE 16 2007 BARTH 2115 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 21 F 88 219-03-8839 Director 04/18/1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 No Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 12918 Bedford Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be John Colin Grahame Margaret Malloy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is C. Edward Barth / Son 13514 New Oakland Drive, Cumberland, MD 21502 permit. Pages 1 and Department of Heal Important: If item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖔 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet. Cem @ Rocky Gap 10/19/2007 Flintstone, MD 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature V Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END CARDIOMYOPATHY Physician 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9☐Unknown 9 I Inknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending hin 24 hours after death. 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident pletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Yamar

31. Date filed (Month, Day, Year)

OCT

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MD

2007

32. Registrar's Signature

Laman

18

900 Seton Drive Cumberland, Maryland

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

d 2 should be filed within 72 hours after death with th and Mental Hygiene.
7 is marked other than "natural", or items 23a or ; traumatic event, the Medical Examiner must be r

permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any Injury or other trau once.

**Physician** 

Examiner

/Medical

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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that the death certificate be ed by the attending physici detached for use as the br Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown
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hysician: this certifica al director, p	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:
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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not I 4 Homicide determined	
To the Hospita within 24 hours To the Funeral completely filled		hysician: To the best of my miner: On the basis of exa and manner stated.
Nithi North	29b. Signature and title of certifier	

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	ysician: To the best of my knowledge, death occurred niner: On the basis of examination and/or investigation and manner stated.			
	00	la Liannaa numbar	221.21	

29b. Signature and title of certifier

29d, Date signed (Month, Dav. Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Kalka 251 East Antietam

Hagerstown, Maryland 21740

State Registrar

31. Date filed (Month, Day, Year) 16 OCT



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			For State	State of M	arylan		•		nd Mental Hy	/giene	9	
		_	1 - State Registrar	10			Certificate of	of Death	100.70	Reg. No	2007	34439
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4	Examin	er		laryland Me	dica	104	7	Hmore		10	. County of Deat	
	Funeral			6. Sex 7. Ag	e (In yrs.			ar   If Under 24		irth	9. Birt	hplace (State or Foreign
	Director		216-13-9628	11 M 2□F	34	Yı	s. World's Da	ys Houis	7/13/1	973		Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town	or Location					10d. Inside City Limits
	Maryl f sho ied a	ļo	Maryland Was	hington	Нао	erst	OWN					1 ZYes 2 No
	r 28a	Directo	10e. Street and Number	111190011	1148	0100	10f. Zip Cod	e		10g. Ci	tizen of What Co	untry?
	th with 23a o		135 Belview Ave				21	742			USA	
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S.	13. Was Decedent If Yes, specify (	of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame	
36	s afte	by Fu	1 K Never Married 2 Marri 3 Widowed 4 Divorced	Armed Forces?  ad 1 ☐ Yes 2 1 1 ☐ Yes, Give Year or Dates:	No		1 ☐ Yes 2 <b>%</b>				Coosifu	hite
5-003b	be filed within 72 hours after death with the Maryland Hylgiene. I dother than "natural", or Items 23a or 28a-f show dother than "matcal Examiner must be notified at event, the Medical Examiner must be notified at	ed b	15. Decedent			16a. D	ecedent's Usual Od	cupation		16h K	wind of Business/	
<u>ن</u> ب	in 72 n "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5	= . \	(	Give kind of work do ife. DO NOT use re	ne during most o tired)	f working	100.11	and of Dasiness,	madaty
717	d with giene ar tha	mo(	12	Conlege (1-40)	)T)	War	ehouse Su	pervisor	<u> </u>	E1	ectrica	1
	- 0 9	Be (	17. Father's Name (First, Middle, I	.ast)					Name (First, Middle		Surname)	
ylan	2 should be and Mental Is marked or raumatic eve	70	Gary Brierley						icia Grams			
Mar	12sh hand 7 Ism traum		19a. Informant's Name/Relationsh			1			or Rural Route Num			(ip Code)
ď	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other traumatic		Gary Brierley/	ratner	20b. F		Disposition (Name of crematory or other		gerstown,		CI/4Z ocation - City or	Town State
aitimor	Pages nent of I int: If ite		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				<i>crematory or other</i> ven Cemet		0/16/2007		•	
	# E # E		21. Signature of Funeral Service I		res	c na	22. Name and Ad					
ñ	permi Depar Impor any Ir		> S.Menle	Sum			1601 Penn	sylvania	a Ave. Hag	gerst	own, MD	21742
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications hat caused only one cause on each li	the death	n. Do no	t enter the mode of	dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Vener	6	T	3.4	rrhag				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of	:	)				
		<u>-</u>	Sequentially list conditions,	b. Due to (or as	a consequ	uence of	:					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events									
Ď,	executed an and rial-transit		resulting in death) Last	Due to (or as	a consequ	uence of)	:					
0/20	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ical		d								
õ ×	death certificate to e attending physic d for use as the b	Physician/Medica	IF FEMALE:					-				
Ž D	ath c attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 ☐ Feta	l death	3 Ectopic pregna				23d. Date of deli Month	very Day Year
5	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown	t time or a	eain	5 ☐ Other (specify	)				
7.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	ns contributing to death b	ut not resi	ulting in t	ne underlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ecords,	quires en sign uid be	ed by	ARDS						1□	Yes 2	DNo 3□Pro	obably 4 Unknown
ည်	2 3 9	Completed							24a. Wa:		24b. Were au	topsy findings available
	The ate his page	E O							per	opsy formed? 2 \( \subseteq No.	death?	completion of cause of
VII all H	sician: The law certificate has t irector, page 2 s	Be (	25. Was case referred to medical examiner?						Death (Check only	one)		
5	dlng Physlcian: The h. After this certificate his funeral director, page	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ER/Outp 28b. Tir	atletit 3 DOA		ing Home 5 ☐ Res			cify)
SION	ding h. funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Da	y Year)	Inju		njury at Vork? □ Yes 2 □ No	28d. Describe	now inju	ry occurred	
2	Atten r deat ector: by the	tica	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of ini	ury - At ho	me, farm	, street, factory, off		28f. Location			ıral Route Number,
5	s afte	Certification:	4   Hornicide	building, et	c. (Specii)	/)			City or To	own, State	9)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification in the funeral director, and the funeral director, and the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director directo	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical 8	Physician: To the best examiner: On the basis o and manner st	f examina	wledge, of tion and/	death occurred at thor investigation, in r	e time, date and ny opinion, death	place, and due to the occurred at the time	e cause(s e, date an	s) and manner as d place, and due	stated. to the cause(s)
	To th Vithir To th comp	Me	29b. Signature and title of certifier				29c. Lic	ense number		29d. Da	ite signed (Montl	n, Day, Year)
•			Lille	SMGIC	AL RE	31024	D	61107		00	ctober	11,2007
3	H-2		30. Name and address of person y		eath (Item	23a) (T	/pe, Print)	, Balt	hunare			
	Sta Registra	_	31. Date filed (Month, Day, Year)	2007 32. Registr	ar's Signa	ture	Agenths	,				,
				- 2			_ <del></del>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Bernard Randolph Brooks 2007 34440 Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Bernard Randolph Brooks, Jr. Physician/ Month Day October 7, 2007 0240 hrs Bernard Randolph Brooks ¬I Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Country) DC **Funeral** Hours Months Days 07-11-1981 Director 26 578-06-5721 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 0c. City, Town or Location à 10a. State Maryland Ob. Count Mount Rainier Prince George's X Yes 2 X No or items 23a or 28a-f show must be notified at once. permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3726 36th Street 20712 USA 723 Harvard Street, 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black If Yes, Give Year or Dates: Yes 2 X No specify: Divorced Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Premium Distributors College (1-4 or 5+) Elementary/Secondary (0-12) of DC 21215-0036 Fork Lift Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Urina Blanton Bernard R. Brooks, Sr. marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 is 723 Harvard Street, NW Washington, DC S Bernard R. Brooks, Sr./Father 20c. Location - City or Town, State If item 2 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10-15-2007 Washington, DC Importants injury or otl Olivet Cemetery Donation 5 22. Name and Address of Facility Marshall's Funeral Home, Inc. gnature of Funeral Service Licenses 20011 4217 9th Street, NW Washington, DC Approximate Interval aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or cor Between Onset and Physician failure. List only one cause on each line Death Medical a. Gunshot wounds of left arm and chest Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed ca physician the burial -UNPENDED 10a-f, perFH, g876, perME, Physician/Medi 23d, Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Day Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death signed by the attending he detached for use as 1 past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available Records, 24a. Was an prior to completion of cause of death? autopsy certificate has rector, page 2 sh performed? 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 examiner? Inpatient 2 V ER/Outpatient 3 this 1 Yes ၀ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) Oct 7, 2007 28b. Time of Injury 27 Manner of Death After Subject shot Certification: 0208 hrs 1 Yes 2 ✔ No Natura! Division Pending d in by the hours after death. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3703 Quincy Street, Hyattsville, MD Suicide determined (Specify) Local Street To the Funeral 4 V Homicide Certifying Physician: To the rest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: In the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical anner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 7, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Chief Medical Examiner David Fowler M.D. 32. Registrar's Signature State

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Registra

OCME

			1 - For State Registrar	State of Man	•	artment of H			ene	31.1.1.1		
8	Physic		1. Decedent's Name (First, Middle, Last, Arthur Eugene Bles					2. Date of Death Month October	Day Yea	3. Time of Death		
12 to 12	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Havre de	e Grace	th	4c. County of De	eath		
d	Funeral Director		204-34-7100	7. Age (//	n yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rear) (	Birthplace (State or Foreign Country) Ennsylvania		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  physician and Department: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show as the burial-transit or process.  Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be rediffed at once.	Examiner To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Naryland  10c. Street and Number  420 North Stokes S  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest graded)  17. Father's Name (First, Middle, Last)  William Blessing,  19a. Informant's Name/Relationship (Ty Nancy M. Blessing)  19a. Method of Disposition  1 Burial 2 Cremation 3 P  4 Donation 5 Other (Specify)  Singular of Funeral Service Licenses  23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	treet  12. Was Decedent Eve Amed Forces?  1	16a. Deced (Give life).  Disab  19b. Mailin 126  20b. Place of Dispo cemetery, crem R.A. Fevre 22 21 20 death. Do not ent 22 23 odeath. Do not ent 25 onsequence of):	1 Le Grace  101. Zip Code  21078  13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry  16b. Kind of Business/Industry						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical E	25. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann eath 1 ** Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifying Physical Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certifier 1 Certi	3c. If yes, outcome of p  1	oregnancy Fetal death 3 = e of death 5 = of death 5 = ot resulting in the uncontrol of the control DOA Other  28c. Injury Work  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	26. Place of De  at ?? fes 2 No  ne, date and place printing, death occur number	1   Yes  24a. Was an autopsy performs 1   Yes 25  ath Check only one  48d. Describe how  28f. Location (Stre City or Town,  a, and due to the cau	212 No 3 2 24b. Were prior to death? 1 24c 24c 25c 25c 25c 25c 25c 25c 25c 25c 25c 25	Day Year  to the cause of death?  Probably 4 Unknown  autopsy findings available or completion of cause of east 2 No  Decity)  Rural Route Number,  as stated.  ue to the cause(s)			
	Sta Registr	-	31. Dale file (Month, Day, Year)	32 Registrar's	91 4	07 20ci	the Us	rionAp	Havred	bacca hi		

				State of Maryland	/ Depa	artment of H	lealth and N	lental Hyg	iene	
			1 - State Registrar		Cer	tificate of	Death	A	eg. No2007	34442
П	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
4	/Medi	cal	Willard Lee Ca  4a. Facility Name (If not institution, give str			4b Ciby Town o	r Location of Death	October	21, 2007 4c. County of Deat	6:00 A.M.
	Examir	ner	66 Dixon Avenue	eet and number)		Aberde				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year		8. Date of Birth (Month, Day	Harfo	hplace (State or Foreign untry)
	Director		212-26-5029	<sup>M 2□ F</sup> 83	Yrs.	Months Days	Hours with.	May 9,		yland
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary P-f eth	to	MD Harfor	rd Abe	rdeen					MXYes 2 ☐ No
	or 28s	Jirec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	72 hours after deeth with the Maryland naturel', or iteme 23a or 28a-1 ehow disal Examiner must be natified at	Funeral Director	66 Dixon Avenue			21001			U.S.A.	
	item item	une	11. Marital Status 12 Never Married 2 Married 12	. Was Decedent Ever in U.S Armed Forces? 1፟ <b>X</b> Yes 2 ☐ No	. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	or, or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WWII	1	I□Yes ŽŪNo	Specify:		Specify: Wh:	ite
2-0	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of		(Give	lent's Usual Occup	during most of work	ing	16b. Kind of Business/	Industry
121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	ine opera	d)		Civil Serv	ice
<b>d</b> 2	filed Hygir other ent,		17. Father's Name (First, Middle, Last)				18. Mother's Name			
ılan	Vental	To Be	George Carty				Ruby B.	Singlet	on	
Maryland 21215-0036	2 sho and 1 is ma	ľ	19a. Informant's Name/Relationship (Type Dorothy P. Carty						City or Town, State, 2	(ip Code)
	1 and 1ealth em 27 ther tr		20a. Method of Disposition			Dixon Ave		rdeen, M		T 01-1-
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow enty injury or other treumatic event, the Medical Examiner must be notified at ance.		1 ☐ Burial 2000 remation 3 ☐ Rer	noval from State cer	netery, crem	ratory or other place	ce)		20c. Location - City or	
altir	mit. Poartme		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee				1		West Cheste	er, PA
<u>~</u>	Depa impo eny ii		* Kustenthy C	balesbee		Tarring- Aberdeen	ss of Facility -Cargo Fur 1, Marylar	neral Ho nd 2100	me, P.A. 1-3399	
			23a. Part1. Enter the disease, or complications, or heart failure. List only one	tions that caused the death.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute	2 1	Tyelo	id le	ukom	16	Onset and Death
П	Examiner			Due to (or as a conseque	nce of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	nce of):					
4	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	death certificate be executed e attending physicien and od for use as the burial-transit	icai Ex	resulting in death) cast	Due to (or as a conseque	nce of):					
687	ficate physis the	edic	d.							
ŏ	eath certific attending pl for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant 23c	t. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d		C-1i			23d. Date of deli	very
о В	e deat he att	Physician/Med	in the past 12 months? 1 □Yes 2 □ No	4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
<u>Р</u>	The law requires that the de ste has been signed by the a page 2 should be detached f		9 ☐ Unknown  Part II. Other significant conditions contri	buting to death but not result	ing in the up	idarhing cauca gui	on in Part I	23e Did to	pacco use contribute to	the cause of death?
Records,	uires tha signed Id be del	d by	3	Balling to doubt but not rosult	ing in the di	derlying cause give	on in Fait i.	1 🗆 Ye	_/_	obably 4 Unknown
Ö	swrequire s been sig	Completed						24a. Was a		topsy findings available
Ä		mo;						autops perfor	med? prior to death?	completion of cause of
Vital	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to edical examiner?				26. Place of Deat			2010
5	hys his	2	1 Yes 2 No Hos			3□ DOA Oth	4   Nursing no		ence 6 Other (Spec	cify)
o	Attending ir death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	280. Describe no	ow injury occurred	
Division of		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre				reet and Number or Ru	ral Route Number,
۵	ital or ars afte rat Dir led in							City or Towr		
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier  (Check only one)  1 Certifying Physic  2 Medical Examine	ian: To the best of my knowler: On the basis of examination	edge, death n and/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the w thin 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number	2	9d. Date signed (Monti	n, Day, Year)
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	7+1	ŀ	30. Name and address of pers in who com	pleted cau e of death (Item 2	3a) (Type, F	Print)	2) 134 C	troot	XL.	Tagina T
	1'		31 Date filed (Month Day Your)	23 Bariatra a Sina	1)	Q II	101	ryland	21001	een
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Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760. this certificate has

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Day 2007 **Physician** PAULINE CARLISLE 6:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Months Director May 27, 1930 217-28-2259 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director Maryland Washington County Clear Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13376 Independence Rd U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Alice Conner Clarence H. R. Myers, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13376 Independence Rd Clear Spring,MD 21722 John A. Carlisle.Sr-husband 20a. Method of Disposition
1 ☑ Bunal 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) 10-13-2007 | Hagerstown, Maryland Rose Hill Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** YEARS /Medical **Examiner** MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner YEARS attending physician and for use as the burial-transil Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icile location 1 | Yes 2 | No 3 | Probably 4 | Junkhown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) 10 Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 ☐ Pending 1 Tes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature ar e of certifier 00062223 Name and address of person who completed cause of death (Item 23a) (Type, Print) red cause of death (Nem 23a) (Type, Print)
TO, 196 TJORIVE, FLLOCRICE, MO-21782 PRAYEEN BOLAKUM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 200 1:25 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9. Birthplate (State or Foreign Home wood Retirement (enter 1/14 If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number **Funeral** Days Hours 1□M 2QF 86 Director 316-18-5869 Sept.21,1921 Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11009 Hopewell Road 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by Specify: White 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Television Company Asssembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Elmer C. Graham Damie Sherrill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Clark (Son) 11009 Hopewell Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory | 10-14-2007 | Smithsburg, Maryland of Funeral Service Lidensee Osborne Funeral Home P.A. 425 South Conococheague St. Williamsport, Maryland 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pot C Parkinson disease or condition resulting in death) End /Medical Due to (or as a consequence Examiner ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of) and Due to (or as a consequence of) aftending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 ☐ Pending investigation Injury 1 Yes 2 🗆 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

13H-1

DHMH 17 Rev 1/2001

State Registrar

Strouge MO 31. Date filed (Month, Day, Year) 1 6 2007 OCT

rouss

29b. Signature and title of certifier

13424 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

l'enns y 1Vania

29c. License numbe

29d. Date signed (Month. Dav. Year)

ELZGORN

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		For State	State of Mary				lental Hy	giene		
		Registrar  1. Decedent's Name (First, Middle, La	n+l	Cei	rtificate of L	Jeath	2. Date of Dea	Reg. No. 20	07	34445
Physicia	an	Mafalda		dido			Month	Day Y	'ear	3. Time of Death
/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	Octobe	r 13, 200		7:30A <sup>M</sup>
Examin	er	25001 Woodfield			Damascu			Monts		
Funeral		5. Social Security Number 6. S	Sex 7. Age (1	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	h   3	Birthpla Country	ce (State or Foreign
Director		181-14-11/2	I□M 2 <b>X</b> F	86 Yrs.	World Days	riodis Willi.	Feb. 2	1921	enns	ylvania
and w		Usual Residence of Decedent  10a. State 10b, County	10	Oc. City, Town or Lo	cation				100	d. Inside City Limits
Maryl f sho	ŏ	Maryland Montgom	erv	Damasc	110					1 ☐ Yes 2 No
r 28a-	Director	10e. Street and Number	Cly	Damasc	10f. Zip Code			10g. Citizen of Wh	at Country	/?
h with	al D	25001 Woodfield	Road		20872			U.S.A	١.	
ems ser mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of His f Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race -		
within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be netified at	by Fu	1 Never Married 2 Married	1 ∐Yes 2 ∭Xlo If Yes, Give		1 □ Yes 2 □XNo	Specify:		Specify:	Whi	
hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E.	Year or Dates:	16a Decer	dent's Usual Occupa	ation		16b. Kind of Busi		
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be file	Be	17. Father's Name (First, Middle, Last	)			18. Mother's Name	e (First, Middle,	Maiden Surname)		
ould I Men narke	၉	Leonard Carb		T		Rose				
12 sh 12 sh 12 sh 12 m 7 is m traum		19a. Informant's Name/Relationship ( Cynthia C. Vogle		ļ	g Address (Street a			-		•
Heall Heall tem 2		20a. Method of Disposition		20b. Place of Dispo	13 Farmvi		Damaso	us, Mary		20872 n. State
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonce.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crer	natory or otner place	í į	\	Reynoldsv	•	
mit. F partm portar / Injur	ł	21. Signature of Funeral Service Lice	··	22	s Cemete Name and Addres	e of Facility	707			-
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/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):						
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the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne of death 5∟	Other (specify)					
that the the the the the the the the the th		Part II. Other significant conditions	contributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the	cause of death?
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Jing F After funera	ion	27. Manner of Death  1   Natural 5   Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Work		28d. Describe h	ow injury occurred	i	
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To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier 1 XCertifying Pr	nysician: To the best of m	ny knowledge, death	occurred at the time	ne, date and place,	and due to the	cause(s) and mani	ner as stat	ed.
the H nin 24 the Fi Tplete	Medical	one)	miner: On the basis of ex and manner stated	i.						
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Sta		31. Date filed (Month, Day, Year)				NOCKVIII	e, mary	Tand 20	850	
Registr	ar	OCT 1 5 20	107 Keen	Signature Apr	West -					

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: npletely filled in by the funeral within 24 hours a To the Funeral I

Registrar

1CHARER Date filed (Month, Day, OCT 12

29b. Signature and title

30. Name and address

445 32. Registrar's Signature

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

EFENSE HIGHWAY ANNAPOLIS

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

David Daganhardt		I- For State	tate of Maryl		artment of rtificate of		l Mental		Reg. No. 2	007	3444
Physician		Registrar 1. Decedent's Name (First, Midd	dle,Last)					2. Date of Dea	ath	3.	Time of Death
Medical Examine		David Ala	n Daga:	nhardt				Month October	Day Yes 19, 2007	ar	1134 hrs
		4a. Facility Name (if not instituti	=	umber)		4b. City, Town, or I	ocation of D	eath	4c. County	of Death	
	4	908 Ferris Wheel Dri		1 7 A /1	I - A bi-Ab al - A	Mount Airy	Titlia-ia- 0	Alles 10 Date of D	Carroll	VI O Diethol	ano (Stata or
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2-	Min	irth (MM/DD/YYY)	Foreign	
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any	ŀ	Usual Residence of Decedent  10a. State 10b. County	,	10c. City	, Town or Locat	ion				10	d. Inside City Limits
d Se,	_	Maryland Cari	roll		Mount	Airv				1	X Yes 2 No
arylan	υı	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country	?
the Mine A	ä	908 Ferris W	heel Driv	e.		217	71		Unite	d Stat	tes
with with ns 23:	교	11. Marital Status	12. Was De	cedent Ever in U		s Decedent of Hisp	oanic Origin?	( Specify Yes or N	o- 14. Race	e - American	Indian, Black,
death or iter	Funeral		Married Armed F	2 No		es, specify Cuban,		ierto Rican, etc.)	VVIIII	te, etc.	
after ral",	á		ivorced If Yes, Give Ye or Dates:			Yes 2 X No			Specify:		ite
hours hatu		15. Decedent's Education (Specific Elementary/Secondary (0-12)		(1-4 or 5+)		nt's Usual Occupati ost of working life.			16b. Kind of Bi	Jsiness/indu	istry
36 nin 72 fhan dical	be	12	) College (	(1-4-01-5+)	Owner	/ Opera	tor		Beer &	Wine	Store
5-0036 led within 72 Hygiene. lother than the Medical	Completed	17. Father's Name (First, Middle	e, Last)	<u> </u>	3,1101			lame (First, Middle,			
215 be file be file rked o	) B	Charles Rober	t Daganha	rdt			Amy ]	sabel Wi	dner		
21, nould the mar is mar tic eve		19a. Informant's Name/Relation						r or Rural Route Nu	-		
MD id 2 sho lith and m 27 is aumati		Karen D. Rycyk	/ Daught					re Mt. A	iry, Mar		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 X Crematic	on 3 Removal f		crematory or ot	sition (Name of cen her place)		otober	200, Location	- City or Tov	wn, State
Page Page ment tant;		4 Qonation 5 Other S	Specify:		ederick	Cremato	cv	22, 2007	Frederi	ick, M	aryland
Balt permit Depart Impor Injury		1. Sign ture of Funeral Servin	e Licensee		22.1	Name and Address	of Facility	stauffer	Funeral	Homes,	, P.A.
	-	23a. Part I. Enter the disease, of	or complications that	caused the deat							and 21771 Approximate Interval
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68760 certificate ding phys	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes	, outcome of pre	gnancy	etal death 3	Ectopic p	regnancy	23d. Date of Month	of delivery Day	Year
x 68	<u>[</u>	past 12 months?		nant at time of d		ther (Specify)	Lotopio pi	ognanoy		24,	
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lea de la co	by P	Part II. Other significant cond	itions contributing	to death but not	resulting in the	underlying cause g	iven in Part l		tobacco use conf es 2 No 3		e cause of death?
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Division tall or Attending as after death.	Certification:	2 Accident Inv	estigation FNG	10/19/200 ice of Injury - At I		et, factory, office b	Λ	Subjec	ct ingeste (Street and Num		Route Number, City
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Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the tire.	Medical	one) 2 Medical Ex	aminer:On the basis	of examination stated.	and/or investiga	tion, in my opinion	, death occur	red at the time, dat	e and place, and	due to the c	ause(s)
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		Patrice W	nonica	- Hal	almo	O.C.I	M.E.		October 2	.0, 2007	
	ľ	30. Name and address of person	•	,		444.5	A D-111	mana MD 040	04		
		Patricia Aronica-Polla		tant Medical			reet, Balti	more, MD 212	U 1		
Sta Registr		31. Date filed (Month, Day, Year OCT 2	3 2007	Registrar's Signa	H 40	ente					

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Physician 10:45 2007 /Medical <u>Orin Jordan Durev</u> <u>October 8,</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) March 8,1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours South Dakota 81 Director 504-18-7676 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 XNo Director Anne Arundel Maryland Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 351 Kingsberry Drive 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1943–64 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify <u>م</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Coordinator of Fed'l. Funds State of Maryland 4 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Eliza Minor Orin J. Durey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerstin M. Durey/ Wife 351 Kingsberry Drive, Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 10-10-07 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Lic 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical sequence of) Examiner Sequentially list conditions, if any loading Limin dain cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed b d be deta Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 TYes 2 X No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide

death certificate be executed P.O. Box 68760. Division or Vital Records,

3altimore, Maryland 21215-0036

24 hours after death.

Funeral Director: After this Hospital or Attending 24 hours after death. filled in by Medical the the ٥

certificate has

Registrar

4 Homicide

(Check only one)

29b. Signature and title of

29a. Certifier

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and ad pleted cause of death (Item 23a) (Type, Print)

31. Date filed ( Day,

1 1 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John Angle Dudley, Sr. October 2007 11:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 440-07-4406 XXM 2 F 87 Director Mississippi July 10, 1920 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 7101 Bay Front Drive, #309 21403 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1942–65 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) College (1-4or 5+) Captain U.S. Navy 5+ 12 should be filed w h and Mental Hygier 7 is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank R. Dudley permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic ev Agnes McConnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee D. Blackwood/daughter 1714 Winchester Road Annapolis, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Arlington Nat. Cemetery 12/26/2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** percorbic /Medical Due to (or - a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Fibilla 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 death? certificate 2 □ No 1∐ Yes 2 🖃 No the Hospital or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 🗌 Yes 1 Inpatient 10 2 ER/Outpatient this 27. Man of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation Injury n 24 hours after death.
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note of filled in by the fi 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 refifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760

To the I within 2. State

DHMH 17 Rev 1/2001

Medical

Registrar

1 1 2007

29a. Certifier

(Check only one)

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29d. Date signed (Month, Day, Year)

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	2	death o	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 ■ No 4 □ Pregna	th 2 ☐ Fetal deat nt at time of death		/			
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	5	ng Phy fter this neral c		27. Manner of Death 28a. Date of						
	2	ttendi death. ctor: A / the fu	icatio	2 Accident investigation	f injury - At home, f			28f Location (Str.	eet and Number or Rus	al Route Number
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		ne Hospi 24 hour ne Funer bletely fill		(Check only 2 Medical Examiner: On the base	sis of examination a					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Seo MENUS RIAL AVE # 105  EMMANY EL OSEI BOAMWHIT			Me	29b. Signature and title of certifier	MW	-		_		_
				30. Name and address of person who completed cause	of death (Item 23a)	) (Type, Print) 5 %	MEM	W RIAS	AVE	# les

Registrar

State

31. Date filed (Month, Day, Year)
OCT 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** NELLIE W. **EDENHART** / A M 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner THE LIONS CENTER CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN • 19,1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 214-07-2738 93 Director MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at ALLEGANY MD CUMBERLAND 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be U.S.A. 721 FAYETTE STREET 21502 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No <u>^</u> Specify: 3 Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SALES CLERK RETAIL STORE of Health and Mental Hygic item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be f and Mental I JOHN T. WHITE BRIDGET BYRNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GREENSVIEW LANE, LONGVIEW, WA ELLEN KATHRYN ROBINSON / DAU. 98632 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1:
Department of He
Important: If iten
any Injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MARY'S CEMETERY 10/20/2007 CUMBERLAND, MD 21. Signature of Funeral Savice Licens Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** OROWANY resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown 9 Unknow as been signed 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ð o bstructive Pulmonary 1 Tes 2 No 3 Probably 4 Nown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate Dementia 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Residence 6 Other (Specify) 1 ☐ Yes 🙎 🙀 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this. 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Accident 5 ☐ Pending investigation To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 3 021244

DHMH 17 Rev 1/2001

MA

Registrar

State

31. Date filed (Month, Day, Year)

OCT 1 8 2007

4 Broo

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Richard Cowden Evans Mont 10/9/2007 9:55am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 150 Dewey Dr. Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9/2/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1 M 2000 F 80 137-20-9293 ŃΥ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes XXNo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 150 Dewey Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2x Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cowden Evans Margaret Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Evans Daughter 150 Dewey Dr. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2007 Baltimore, MD Metro Crematory 21. Signature of Funeral Service icensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 1 23a. Part1. Enter the diseas shock, or heart failure. 12 Ridgely Ave. Annapolis, MD 21401 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) irrhosis 5 years of Due to (or as a consequence of): Alcohol usage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1☐ Yes 1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

2

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner Physiclan/Medical ģ Completed Be Certification: To

and burial-tran aftending physician the as nse ξ the this certificate After Director filled in by

The law requires that the death certificate be executed

or Attending Physician:

Hospital

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a Medical

State

29b. Signature and title of certifier

Stephen Killian

OCT 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3169

Registrar

29c. License number

Braveston St, # 201; Edgewater, MD 21037

29d. Date signed (Month, Day, Year) October 10, 2007

			For State	State of Mary		ertificate of		-	_			
0			Registrar  1. Decedent's Name (First, Middle, Las	st)			Death	2. Date of De	Reg. No.	2007	3 Jime	453
1. W	Physici		Stephen Charles					Month	Day	Year 2007	5.30	ам
	/Medic Examin	- 230	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D			County of Deat		
	LAGIIIII	CI	Holy Cross Hosp	ital		Silver	Spring			Monta	omerv	
- 144	Funeral		5. Social Security Number 6. S	, ,	n yrs. last birthda		If Under 24 I		th v. Year)	9. Birti	nplace (State	or Foreign
	Director		220-58-7902	XM 2□F	57 Yrs.	I World Days	I TIOUIS II	Aug. 2				on, DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or I	ocation					10d. Inside (	City Limits
	Aaryla f sho ed at	ō		Manakanan		m . 1	,					s 2 No
	the 28a-	Director	Maryland 10e. Street and Number	Montgomery	<u>y</u>	Takoma P	ark		10g. Citiz	en of What Co	untry?	
	3a or st be		8007 Garland A	venue, Apt.	2		2091	2		USA		
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		. Was Decedent of	Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	)- 1	4. Race - Ame		
9	after or ite mine		1X Never Married 2 Married	1 ☐ Yes 2x No		1 ☐ Yes 2 No		derio i liodii, elo.)	1		hite	
21215-0036	ural", II Exa	d by	3 Widowed 4 Divorced	Year or Dates:	10.0							
5	"nati	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occu re kind of work done DO NOT use retire	during most of	working	16b. Kin	d of Business/	ndustry	
12	withii ene. than he M	崩	Elementary/Secondary (0-12)	College (1-4or 5+)		Mason			Cor	struct	ion	
	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)	)			18. Mother's	Name (First, Middle	, Maiden S	Surname)		
lan	ald be denta rked ric ev	To B	Donald Edward Fin	nnell			Pat	ricia Mar	у Кае	elin		
Maryland	shot and N s mal		19a. Informant's Name/Relationship (	Type. Print)	19b. Ma	ling Address (Stree	t and Number o	r Rural Route Numb	er, City or	Town, State, 2	(ip Code)	
	1 and 2 Health em 27 I		Diane Marie Ford				d Drive	, Bethesd				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐	3D		ematory or other pla		Date		ation - City or	Town, State	
tim	tment tant:		4 ☐ Donation 5 ☐ Other (Specif	v)				ct885r 13	*******	kandria	, Virg	inia
Bal	Depar Depar mpor any ir		21. Signature of uneral Service Lice	nsee				ns Funera				
			23a. Part1. Enter the disease, or com	plications that caused the				1vd, W, S		Sprin		
	Dharfeira		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						09	Approximation Interval Be Onset and	etween d Death
	Physician /Medical		disease or condition resulting in death)	a. Lung Cano							4 Mo:	nths
	Examiner			b. Multiple		24254264					4 Mon	the
	- s	Je.	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a c		000000000					1 11011	CIIS
B	ecute ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Terminal		n					2 Wee	ks
8760,0	certificate be executed rding physician and ise as the burial-transit	Ě	resulting in death) Last  Due to (or as a consequence of):									
	physic	dical		d								
9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy				,	3d. Date of del	iven/	
Вох	death e atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 [ 4□Pregnant at tim		☐ Ectopic pregnand ☐ Other (specify) _	су			Month	Day	Year
O.	t the	hysi	9 Unknown	9□Unknown								
S, D	tw requires that s been signed by should be deta	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco us	se contribute to		
ord	The law requires te has been sign age 2 should be							_ 10	Yes 2	]No 3□Pr	obably 4	<b></b> Unknown
ecc	<i>ω</i> ω <i>α</i>	Completed						24a. Was		24b. Were au	topsy finding	s available cause of
= E		Son							ormed?	death? 1 ☐ Yes	·	
/ita	iclan: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	5 1				Death (Check only	one)	·		
or Vital Record	Physiclan: r this certific ral director,	P.	1 Yes 2 No		2 ER/Outpati	BILL SOLDOA		ng Home 5□Res			cify)	
on C	Jing I. After fune	ioi	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		We	uryat ork? ∃Yes 2⊟No	28d. Describe	now injury	occurred		
Division	or Attending after death. Director: Aftel I in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		- At home, farm,			28f. Location	Street and	l Number or Ri	ural Route Nu	ımber.
<u>S</u>	after after Dire	Certification:	4 Homicide determined	building, etc. (	Specify)				wn, State)			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Exam	nysician: To the best of r niner: On the basis of ex	camination and/or							∋(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated	ı.	29c. Licer	se number		29d. Date	e signed (Mont	h, Day, Year)	)
	F 3 F 8		Barbara &	( 000 ) 1 0	0,	D65485				0/10/		
	5		30. Name and address of person who			e, Print)			, ,	1,010	T	
			Barbara Supanich,	'MD 1500	Forest (	Slen Road	, Silve:	r Spring,	MD 2	0910		
	Sta Regist	_	31. Date filed (Month, Day, Year)	32. Fegistrar's	Signature	harte						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 6, 2007 3:25 P M Stephen Kenneth Fisher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 11139 Maryland Manor Court Germantown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 24, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2□ F Virginia 227-78-3055 55 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. The state of Health and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show hart: If item 27 is marked other than "natural be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 USA 11139 Maryland Manor Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, 2 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lila Lorine Smith Kenneth Brice Fisher ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16564 U.S. Highway 550 Aztec, NM 87410 <u>Victoria Luna/slster</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 10/12/07 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation SERVICE P.O. Box 784 BEVERLY L. HECKNOTTE P.A. CLARKSVILLE, MO 31039 21. Signatura of Funeral Service License MO1251 23a. Part1. Enter the #/ ease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart for ure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician Colorectal CARCINOMA MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2: autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital

State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

M.D. 18/11 Prince KAJAGOPAI 32. Registrar's Signature Year) 1 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

1 🔀 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Marylan	_	artment of F		nd M		giene Reg. No.20	07	34455
-	Physici		1. Decedent's Name (First, Middle, Margaret	Last)	Gr	umble	S			2. Date of Dea		Year	3. Time of Death 9:45а м
	/Medic Examin		4a. Facility Name (If not institution, Alfred House	Elderca				er Sp	rin	g	4c. County Mor	itgor	
	Funeral Director		247-44-1335	6. Sex 7 1 □ M 2 🔀 F	. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	71912	9. Birthr	place (State or Foreign pry) Carolina
	Maryland a-f show filed at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Montg	omery		y, Town or Lo	cation Spring					1	0d. Inside City Limits 1 ☐ Yes 2∑ No
	h with the 23a or 28a st be not	al Director	10e. Street and Number 4 Broomall C	ourt			10f. Zip Code 2090	6			10g. Citizen of V		ntry?
36	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by Funeral I	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford  at 1 Yes 2 If Yes, Give Year or Dat	es? ₽ <b>⊠</b> No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		in? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Rad Blad Specify	k, White,	ean Indian, etc. ite
1215-0036	be filed within 72 hours after death with the Marylar ttal Hygiene. d other than "natural", or items 23a or 28a-f show or other than "natural", or items to notified at event, the Medical Examiner must be notified at	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed)	4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most d)		99	16b. Kind of B Clot Manui	hin	<b>a</b> .
and 2	tould be filed v Mental Hygie narked other t natic event, th	To Be Co	11 17. Father's Name ( <i>First, Middle, I</i> Nathaniel M.		<del></del>	ra	ctory w	18. Mother	's Name	(First, Middle, Bell	Maiden Surnar		
Mary	ss 1 and 2 should of Health and Men item 27 is marke other traumatic	ř	19a. Informant's Name/Relationsh Charlotte Abr	ip (Type. Print) ams/Daug	hter	19b. Mailir 9309	ng Address (Street Harris	and Number ons F	r or Rura 'arm	Way G	or, City or Town, Saither	State, Zip	rg,Md2088
Baltimore, Maryland 2	nit. Pages 1 a artment of He ortant: If item Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other	3 □Removal from S	tate 20b. F	Place of Dispo cemetery, crei Chesap	sition (Name of matory or other pla Deake C1	ce)		ate 0/2007	Belts	-	
Ball	permit. Depart Import any Inj		21. Signey e of Funeral Sovice I	<i>K</i> ,	नारी	9		umbia	ı Bl	vd.Sil	ver S		g,Md20910
	Physician /Medical		23a. Part1. Enfer the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Deh	<sub>ch line.</sub> ydrat	ion	er the mode of dyi	ng, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death  3 days
	Examiner <sup>.</sup>	er	Sequentially list conditions, if only action to immediate cause. Enter Underlying Cause (Disease or injury		ras a conseq r Nut ras a conse		nal Ina	nitio	n			- 5	1 week
ر ر	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		heime	rs Di	sease					•	Years
68/60,	tificate be g physicia as the bu	ledical		d. Chr	onic	Obstr	uctive	Lung	Dis	ease		1	Years
C. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2□Feta nt at time of o	aldeath 3	Ectopic pregnanc Other (specify) _	у				te of deliv	ery Day Year
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying cause gl	ven in Part I.		23e. Did to			he cause of death?
Vital Hecords,		Completed							_	24a. Was autop perfo 1□ Yes	rmed?	prior to co death?	opsy findings available impletion of cause of
	> .∞ ∞	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2	ER/Outpatier	nt 3□ DOA Oti			(Check only o		aner (Spaci	ssisted Nying
sion or	ending tath. or; After he fune	ation: T	27. Manner of Death  1 Natural  2 Accident  5 Pending investig	ation	Injury , Day Year)	28b. Time o Injury	Wa	ryat rk? ]Yes 2∐N	2		now injury occur		xxiiig
DIVISION	To the Hospital or Attend within 24 hours after death To the Funeral Director; / completely filled in by the f	Certification:	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flace of buildin	g, etc. (Speci	fy)	eet, factory, office			City or Tov	vn, State)		al Route Number,
	he Hosp in 24 hou he Fune pletely fi	Medical		g Physician: To the t Examiner: On the ba and mann	sis of examina								
)	3 F F F F F F F F F F F F F F F F F F F	M	29b. Signature and title of certifier	) Lan	Mo	27	29c. Licen:	se number 5410			Oct.9		
			30. Name and address of person Oliver Lawle				Print) e Phill	ip Dr	.0li	ney,Md	20832		
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 12	2007	gistrar's Sign	ature	all						

			1 - State Registrar	State of Maryland / Depa	tificate of			2007	34456
Ī	Physici		1. Decedent's Name (First, Middle, Las.	iam Grove Jr.			2. Date of Death Month OCT. 14		3. Time of Death 9:58a. M
	/Medio		4a. Facility Name (If not institution, give 15106 Hicksvi			Spring,		4c. County of Dea	gton
	Funeral Director			x	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, ) Feb 26,	1941 Fu	thplace (State or Foreign ountry) nkstown, MD
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County MD Washin	gton   10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23s or 28e	Funeral Director	10e. Street and Number 15106 Hicksvil	le Road	10f. Zip Code 2172	22		g. Citizen of What C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or Items 23s or 28s-f show any figury or other traumatic event, Ire Medical Exercises in a final be notified at once.	by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1959-	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	to oto
Maryland 21215-0036	d within 72 ho giene. ir than "netui ire Medical	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th grade	de completed) (Give	dent's Usual Occup kind of work done DO NOT use retired ar Cutte	during most of work d)	ing t	Sb. Kind of Business rucking mfg.	r/Industry
/land	2 should be filed and Mental Hyg is marked other raumatic event,	To Be C	17. Father's Name (First, Middle, Last) George Willia	m Grove Sr.			e (First, Middle, Ma Edna Mas		
, Mar	and 2 sho ealth and m 27 is ma		19a. Informant's Name/Relationship (T) Mary M. Grove	wife 1510	06 Hicks	sville R	Rd. Clea		g,MD 21722
altimore,	Pages 1 Iment of H tant: If Itel jury or oth		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation 3 ☐ 1  4 ☐ Donation 5 ☐ Other (Specify,	raikilead	d Cemete	- 200	10, 17	oc. Location - City of Big Pool	, MD
Ball	Departit Depart Import any In		21. Signature of Funeral Service Licens	Tiny	P.O.BOX	310 Cle	ar Spri	ng, MD	Home, Inc
	Pnysician /Medical Examiner		/23a. Part. Enter the disease, or comp shock, or head failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not entine cause on each lin  a	er the mode of dyin	g, such as cardiac	or respiratory arres	me	Approximate Interval Between Onset and Death  Hmonth
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consequence of).					
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of):					
Box 6	death certifi e attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
<u>α</u>	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause give	en in Part I.			o the cause of death? robably 4 Unknown
<u> </u>	The ate h page	Completed					24a. Was an autopsy performs	prior to death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Othe		h (Check only one)	ce 6 □Other (Spi	noife!
	ding Phys	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)  28b. Time of Injury		y at	28d. Describe how		ecity)
É	or Attenditer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	edicai (	29a. Certifying Phy (Check only one)	sician: To the best of my knowledge, death iner: On the basis of examination and/or invand manner stated.	n occurred at the tin restigation, in my o	ne, date and place, pinion, death occuri	and due to the cau red at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
ŧ	To the within 2 To the comple	×	29b. Signature and title of certifier	anda	29c. Licenso	DH64	73 (	d. Date signed (Mon	th, Day, Year)
54	Sta Registr	100	30. Name and address of person who control of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o	ompleted cause of death (Item 23a) (Type,  1 1 1 2 32. Pigistrar's Signature	Print)	AL CT	: Hag	erstow	n, mo 21740

			1 - For State Registrar	State of Ma	aryland	-	artment o tificate			ental Hy	giene Reg. No.	007	34457	
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary Patricia Grove							2. Date of De Month /	Day	2007°	3. Time of Death 2:20 A M	
4	/Medio		4a. Facility Name (If not institution, give s				4b. City, To	wn, or Location	on of Death	107		ounty of Death		
	Exami		Williamsport Reti	rement Vi	llage	e	Williamsport					Washington		
	Funeral Director		5. Social Security Number 6. Sex 217−12−1208	7. Age M 2∏ F	83	ast birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of B   Months   Days   Hours   Min.   11/1/			Day, Year) Country)				
	ס		Usual Residence of Decedent		10: Cit.	. Town or Lo							10d. Inside City Limits	
	faryla hov	or	10a. State 10b. County  Maryland Washing	rton		erstow							1 TYes 2 □ No	
	286-1	Directo	10e. Street and Number	3011	mage	EISCOW	10f. Zip Co	ode			10g. Citize	en of What Cou	untry?	
	h with	ai Di	17903 Orchard Terra	ace				2174	0		1	USA		
	r deal	Funeral		2. Was Decedent E Armed Forces?		S. 13. \	Was Deceden f Yes, specify	t of Hispanic Cuban, Mex	Origin? (Speican, Puerto	ecify Yes or No Rican, etc.)	0- 14	Race - Amer Black, White		
36	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f ehow he Madical Exercites must be invitted at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ♣ N If Yes, Give Year or Dates:	lo		I□Yes 2€	No Spec	city:		S	pecify: Whi	ite	
Ö	2 hou	ted	15. Decedent's Educ (Specify only highest grade	ucation 16a. Decede			dent's Usual Occupation kind of work done during most of working			16b. Kind	of Business/li			
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT use i	etired)		ng				
, 5	Hygie Hygie ther t	e Co	12 17. Father's Name (First, Middle, Last)	2		Tea	cher A			(First, Middle		cation		
lan	Mental Red o	To Be	George N. Payette					Ма	ry 0.	Ogden				
Maryland 21215-0036	2 short	_	19a. Informant's Name/Relationship (Typ	oe, Print)		1	-					Town, State, Z	ip Code)	
e,	1 and Health em 27 ther tr		Mark S. Grove/Son  20a. Method of Disposition		20b. PI	Line III	INTALL sition (Name		,	eysvill Date		2343U ation - City or T	Town. State	
JOIL L	Pages ent of ht: If Its		1 Surial 2 Cremation 3 ☐Re 4 ☐Donation 5 ☐ Other (Specify)	emoval from State	Ce	emetery, cren	natory or other	r place)	10/15	5/2007		stown,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or Iteme 23a or 28e-f ehow any injury or other traumatic event, the Medical Example intertual barratified at ODGE.		21. Signature of Funeral Service License	0		22	. Name and A	Address of Fa	acility Res	st Have	n Fun	eral Ch	napel	
_	20 = 20	100	1 S. Mark Su	No	46 446-			•			_	own, MI	Approximate	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final							-			Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	CTIVE	pulmi	onarc	dise	ase		years	
п	Examiner		Sequentially list conditions b.											
	rted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	Jence of):								
oʻ	cate be executed physicien and the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as	a consequ	uence of):								
8760	cate be chysici the bu	dicai	d.						-					
9 X	leath certific attending p	νМе	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					===11/01		23	d. Date of deli	very	
). Box	Attending Physiclen: The law requires that the death certific refaith.  cloath.  ector: After this certificete hes been signed by the attending put the funeral director, page 2 should be detached for use as by the funeral director, page 2.	Completed by Physician/Me	in the past 12 months?	1□Live birth 4□Pregnant at 9□Unknown			JEctopic pregi Other (speci					Month	Day Year	
<u>G</u>	that the	Phy	9 ☐ Unknown  Part II. Other significant conditions con	tributing to death bu	ut not resu	ulting in the u	nderlying caus	se given in Pa	art I,	23e. Did	tobacco use	a contribute to	the cause of death?	
rds,	quires n sign uld be	d b	atherosclerotic	heart	di:	seas	ટ_			1 🖄	Kes 2□	No 3 □ Pro	obably 4 Unknown	
9 0 0	law re es bee 2 sho	plet								24a. Was	s an	24b. Were au	topsy findings available completion of cause of	
<u> </u>	: The cete h	Сош								perf	ormed? 2 No	death?	2 No	
<u> </u>	siclen certifi irector	Be c	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatie	0 🗆	ER/Outpatien	- 2 DO4	1	- /	(Check only		Other (Spec	4.1	
0	g Phy er this eral d	n: To	27. Man r of Death	28a. Date of Injur (Month, Day	y	28b. Time of Injury		Injury at Work?		28d. Describe			:iry)	
sior	eath. or: Aft	catio	1 ▼Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	(7701117, 24)	,		М	1 ☐ Yes 2						
Division of Vital Records, P.O.	after d after d Direct d in by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulg	ury - At ho c. (Specify	me, farm, str	eet, factory, o	ffice			(Street and i own, State)	Number or Ru	ral Route Number,	
	To the Hospital or Attending Physiclen: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detached.	edical C	29a. Certifier 1 ★ Certifying Phys (Check only one)		examinat									
	To th within To th compl	Me	29b. Signature and title of certifier	-		Δ		icense numb				signed (Month		
)			Cypthia Ku					474					2,2007	
5	H-3		30. Name and address of person who con		eath (Item	23a) (Type, い川になん	Print)	+ Ner	Sing	Home,	124	North	yland yland	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signal	ture	_	2776	UT, U	CHOW	24061	· Mac	J	
	Regist	rar	OCT 1 5 20	07 Kana	***	M. A	and I							

	1	For State Registrar		Cer	tificate of L	Death		g. No. 2	007	34458
Physicia	an	Decedent's Name (First, Middle, Last	•				2. Date of Deatl Month	Day	Year	3.4 Ime of Deam
/Medic	_	Milton Allen Ga			4b. City, Town, or	Leasting of Death	October		inty of Death	4:20 P M
Examin		4a. Facility Name (If not institution, give			Woodlawn	Location of Death			imore	
		Augsburg Lutheran 5. Social Security Number 6. S			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign
Funeral Director			XIM 2□ F 67	Yrs.	Months Days	Hours Min.	(Month, Day, Jan 29,	<sup>Year)</sup> 1940	) Mary	rland
filed within 72 hours after death with the Maryland Hygiene.  the rhan "natural" or items 23a or 28a-f show ther than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notifiled at	5	10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits 1 □ Yes 2 🛣 No
he M 28a-f otifile	Director	MD Baltimor  10e. Street and Number	e Balt:	imore	10f. Zip Code		11	On. Citizen	of What Cou	ntrv?
a or	直				21227			SA		•
eath IS 23 must	era	2822 Tennessee Av	12. Was Decedent Ever in U.S	S. 13. 1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp		14.	Race - Americ	
d within 72 hours after death with the Marylan siene. Then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1X Yes 2 No If Yes, Give		lf Yes, specify Cuba 1 □ Yes 2 <b>ሺ</b> No	n', Mexican', Puèrto Specify:	Rićan, etc.)		Black, White, ec <i>ify:</i> Whit	
uraľ	Q D		Year or Dates: 1951-		dent's Usual Occupa	ation	T		of Business/in	
"nat	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ina i		Safet	-
than than than	틸	Elementary/Secondary (0-12)	College (1-4or 5+)		Fighter		<u>-</u>			ity Gov.
Hygik Ther Int, th	Š	17. Father's Name (First, Middle, Last	)	PILC	TIGHTEL	18. Mother's Name				
e d d d d d	Be	Henry Charles Gab				Martha J	ane Hetz	elbei	ger	
should be filed vand Mental Hygies marked other i	ပ္	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street a					o Code)
s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Sharon R. Gable/w	rife	2822	Tennessee	Avenue	Baltimor	e, MI	21227	7
		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specia	Hemovai from State		osition (Name of matory or other plac te Cremato				ion - City or T	
permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice	Asee AH	GC	2. Name and Addres	ss of Facility Crematio	n Servic	e P	.O. Box	× 784
		terry 7 H	elle Mol	251 B€	everly L.	Heckrott	e, P.A.	Clarl	ksville	Approximate
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	. Do not em	ter the mode of dyin	g, such as cardiac	or respiratory arri	est,		Interval Between Onset and Death
hysician		Immediate Cause (Final disease or condition	a. tan	orano	: Concer				- 1	
Medical		resulting in death)	Due to (or as a consequ	uence of):						
aminer	L	Sequentially list conditions,	b							
#	Examiner	Sequentially list conditions, if any, leading to immediate cause. En let underly in Cause (Disease or injury	Due to (or as a consequ	ience of):						
and trans	am	that initiated events resulting in death) Last	c	uence of):						
cian a			Due to (or as a consequ	ience oi).						
physic the b	edical		_d							
ling p	Me	IF FEMALE:	23c. If yes, outcome pf pregna	nov.				-00	Data of dalli	
attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3	☐Ectopic pregnancy ☐ Other <i>(sp</i> ec <i>ify)</i>	1		230	I. Date of delive Month	Day Year
the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of de 9⊡Unknown	eau ot			-			
d by letac	Ph	Part II. Other significant conditions	contributing to death but not resu	ultina in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
an signed by the attending physician and uld be detached for use as the burial-transit	ed by	- art II. Other significant conditions					1□Y	es 2□I	No 3□Pro	obably 4 nknow
s been si	Completed	·					24a. Was a		24b. Were au	topsy findings availab ompletion of cause of
age 2	E C						autop: perfor 1∐ Yes	med?	death?	2 No
certificate ector, pag		25. Was case referred to medical				26. Place of Dea		-		
s cert	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth		ome 5 Resid		Other (Spec	eifv)
After this certificate har funeral director, page	.: To	27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe h			
: Affe	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) on	Injury		Yes 2 ☐ No				
fter deal <b>Director</b> in by the	Certification:	3 Suicide 6 Could not to determined		ome, farm, st	treet, factory, office		28f. Location (S City or Tow	treet and t n, State)	Number or Ru	ral Route Number,
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 12 Certifying P	hysician: To the best of my kno miner: On the basis of examina	wledge, dea	th occurred at the ti	me, date and place	, and due to the or	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
hin 24 <b>the l</b> πplet	Medical	one)	and manner stated.		29c. Licens				signed (Month	
=	2	29b. Signature and title of certifier					4		10/ 67	., Juy, / our/
₩ <b>6</b>	1	Raymond MM	am mo		Da	7633		,0	10/0/	
<b>`</b>										
<b>v</b> 3− / 		30. Name and address of person who	completed cause of death (Item			21136	Raym	) hre	niles	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 34459 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Rosie Virginia Gantt 9:00 P Oct 10, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 3irthplac Country) MD 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 579-36-0576 Yrs. 79 Director Feb 9, 1928 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits "natural", or items 23a or 28a-f sho MD Director Calvert Prince Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 West Dares Beach Rd. Apt.#413 20678 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 ₩ Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matu any injury or other traumatic event, the Meatikan 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Gross Matilda Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry Gantt /Son P.O. Box 11837 Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □Removal from State 10/16/07 St. John UMC Cemetery Lusby, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 Part1. Enter the diseas shock, or heart failure. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** periphi morte disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the bunal-transi Due to (or as a consequence of): attending physician Physician/Medical as IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No P 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad hiss of pers in who completed cause of death (Item 23a) (Type, Print) Silvia Bongers Batong, M.D. 11845 HG Trueman Road Lusby, MD 20657 31. Date filed (Month, Day, 32. Registra s Signature State OCT Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Division or Vital Records,

		·	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment o	of Health and of Death		giene 00	7 34460
	Physic	an	Decedent's Name (First, Middle, Last  VENINTENTIL CADA				B (1887-17)	2. Date of Dea Month	ath	3. Time of Death
	/Medi Examir	ai	KENNETH GARD  4a. Facility Name (If not institution, give			4b. City. Toy	wn, or Location of Dea	OCTOBE	R 16 20	07 1:30 A <sup>M</sup>
	LAdiiii	ici	1400 PERRYWOOD COU		203		ABERDEE			FORD
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday	If Under 1 Y   Months   D	ear If Under 24 Hr ays Hours Mir	. (Month, Day	y, Year) 9.	Birthplace (State or Foreign Country)
	Director		139-60-5677		46 Yrs.			JAN 19,	, 1961	NEW JERSEY
	anylan ahow det	Ļ	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	h the Maryland r 28a-f ehow	Director	MARYLAND HARE	ORD			BERDEEN		10- 04	1 No 2 No
			1400 PERRYWOO	OD COURT.	АРТ 203	10f. Zip Co	21001		10g. Citizen of Wha	it Country?
		Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent	t of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No-		American Indian, White, etc.
36	a o H	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X N If Yes, Give	lo	1 ☐ Yes 2 <b>X</b>		nto Thoun, Sto.)	Specify:	
21215-0036	"natural",		15. Decedent's Edu	Year or Dates:	16a. Dece	edent's Usual O	ccupation		16b. Kind of Busin	
215	ithin 7.	Completed	(Specify only highest grad Elementary/Secondary (0·12)	e completed) College (1-4or 5	life.	s kind of work d DO NOT use n	lone during most of w etired)	orking		,
	e filed within al Hygiene. I other then '	Con	11 17. Father's Name (First, Middle, Last)			MAIN	I'ENANCE	an a (Sina Middle	CHUR	CH
land	id be f ental f ked of ic eve	To Be	SPEAKER GARNETT					ame (First, Middle,  S COUNCII	,	
Maryland	2 should be and Mental te marked of raumetic evi	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ing Address (St	treet and Number or F			te, Zip Code)
	s 1 and 2 should be filed within 72 hc I Haalth and Mantal Hygiene. Item 27 ie marked other then "natur other traumetic event, the Mudical		KENNETH COUNCIL /	COUSIN	1001 51	552 HARI	RPARK COUR			LAND 21040
Baltimore,	m O - L-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F			matory or other	r place)	Date	20c. Location - Cit	
altin	permit. Pege Department of Importent: if any injury of once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		R.A. FERI		O, INC 10	/19/07	WEST CHE	STER, PA
ä	Depa impo any ic		1 day Sco	at col	encer	LISA S	SCOIT FUNE EWIS STREE	RAL HOME,	P.A.	MARYLAND
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not er	ter the mode of	dying, such as cardia	ac or respiratory arr	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Meh	estatic	ang	cara	homa	В	Onset and Death
	Examiner			Due to (or as a	a consequence of):	1				1
	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of);					
8760,	sate be execu- physicien and the burial-trar	dlcal E	L.	1	30,130,420,130,017.					
.89	rtificat ng phy as th	യ ⊢	IF FEMALE:							
Вох	eath certific ettending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth	2 ☐ Fetal death 3 l	⊒Ectopic pregn			23d. Date of Month	f delivery Day Year
o.	that the de led by the e detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5	Other (specif	y)			buy .ou.
ď.	The law requires that the death certific site hes been signed by the ettending p bage 2 should be detached for use as	by P	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the t	inderlying caus	e given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
Records,	w require been sig should b	ted						134	es 2□No 3[	Probably 4 Unknown
3ec	hes by	Completed		<u> </u>				24a. Was a autops	24b. Wer	e autopsy findings available r to completion of cause of th?
		e Co	25. Was case referred to medical						2.2 No 1□	
f Vi	Physician: this certific al director,	To B	examiner?	lospital:	nt 2 ER/Outpatie	nt 3 DOA	Oth	eath Check on or Home 5 - eside		Specify)
	ding Ph After th funeral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	y 28b. Time (		Injury at Work?	1	ow injury occurred	
Division	deatl deatl tor: the	icati	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Inju	ry - At home, farm, st		1 ☐ Yes 2 ☐ No	29f Location (S	troot and Number of	r Rural Route Number,
É	o € 5.⊆	Certification:	4 Homicide determined	building, etc	. (Specify)	reet, factory, on	lice	City or Town	n, State)	r nurai noute Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical Examil	ner: On the basis of	examination and/or in	h occurred at the	ne time, date and place	e, and due to the curred at the time. d	ause(s) and manne	or as stated.
	To the Ho within 24 I To the Fu completely		one)  29b. Signature and title of certifier	and manner star	ted.		cense number		9d. Date signed (M	
	F 5 F ŏ		All in	Inda-	MA				10/16/	
					ath (Item 23a) (Type	Print)	4780 evaeen	1	, , , , ,	•
			A. MROWIFE (16)		en Pla- r's Signature	e. Ab	eraeen	MA	2100,	/
	Sta Registr		UCT 1 7 2	007	as Signature	Parson				

Keuneth

Farnet

			1 State	partment of Health and M <i>ertificate of Death</i>	ental Hygien	
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Ľ	Physicia		Edward W. Green		October 4	Year 1:00 P M
\	/Medic Examin	2 3	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
<i>!</i> —	Funeral		St. Thomas More Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Yea.	
×	Director		216-12-6217 88	•	Feb. 6, 1	919 Clinton, Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary f sho	ţo	Maryland Prince George's Hyattsv	ri11a		1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	h with 23a o st be		4922 LaSalle Road	20782	U	nited States
	ems ems	Funeral		<ol><li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
စ္တ	be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Merical Examiner must be notified at		1 M Never Married 2 Married 1 Y Yes 2 No If Yes, Give	1 ☐ Yes 21 No Specify:		Specify: African
Ö	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. De	cedent's Usual Occupation	16b.	American Kind of Business/Industry
7	in 72 "na" r	Completed	(Specify only highest grade completed) (Gifte	ive kind of work done during most of work e. DO NOT use retired)		•
7	with jiene. r thar th. N	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Military Service	G	overnment
פ	al Hyg other	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)
<u> a</u>	should be and Menta s marked umatic ev	To E	Willie Green	Eliza (	Unknown)	
Maryland 21215-0036	2 sho and l is ma auma		Toda militario i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talifori i talif	ailing Address (Street and Number or Run		
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altimore,	S to II			rematory or other place)		•
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Ba	permit. Page Department ( Important; If any Injury or once.		Hetter old Bandall	4001 Benning Road		
	718 OH		23a. Part1. Fiver the disease, or complications that caused the death. Do not shock, cheart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- Potic CardiovAsi	was Dis	Onset and Death
P	/Medical		resulting in death)  Due to (or as a consequence of):	,		
	Examiner	_	Sequentially list conditions, b.			
	bei isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
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ŏ	th cer tendir r use	an/N	IF FEMALE: 23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
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Vital Records, P.O. Box	res that the death certificing to the attending for the detached for use as	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
ds,	signe d be d	d by	Hypertension Prostate Can		1 □ Yes	2 No 3 Probably 4 Unknown
S	w require been signated should b	etec	periphenal Vasadan Disease		24a. Was an	24b. Were autopsy findings available
æ	he lar e has age 2	Completed by Physician/Me	Right Below Knee amportal	-	autopsy performed 1 Yes 2 ☑	prior to completion of cause of death?
ta	an: T tiflicat tor, pa	Be Co	25. Was case referred to medical		h (Check only one)	NO TITES ZINO
	is cer direct	To B	examiner? 1	itient 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 □Other (Specify)
0 0	ng Ph fter th neral	L:uc	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tim		28d. Describe how in	njury occurred
Sio	tendli eath. or: A the fu	catic	2 Accident investigation	M 1 Yes 2 No		
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
	pital ours a leral [		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certifice within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examiner: On the basis of examination and/o one) and manner stated.	or investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
			Thullen Word ha	D0185	2 00	tuhen 4,2007
			30. Theme and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	DIL.	twhen 4,2007
	-		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A NEWSPORT	ICH 1740	IUZILL IND ZCOJ
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			For State Registrar	State of Maryland		artment of rtificate o		nd Mental Hy	giene Reg. No. 🤈 🎧	07	21.1.62
\$ P	Physici		1. Decedent's Name (First, Middle, Last) Bing	Wai			Hum	2. Date of De Month Octobe	eath C U	<b>U</b> / 007	3. Time of Death 11:18A. M
	/Medio Examin		4a. Facility Name (If not Institution, give s 5227 Palco Place	treet and number)		4b. City, Town Colleg	, or Location of E e Park		4c. County Prince		orge's
	uneral rector		5. Social Security Number 6. Sex 1 以 1 以 1 以 1 以 1 以 1 以 1 以 1 以 1 以 1	M 2□F 7. Age (In yrs. I		If Under 1 Year Months Day		Hrs. 8. Date of Bin (Month, Date Nov. 6,	th 1918	9. Birthp Cour Chin	place (State or Foreign htry) 13
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n with the h	3a or 28a- st be notifi	al Director	10e. Street and Number 5227 Palco Place	0		10f. Zip Code			10g. Citizen of V United		-
<b>5-0036</b> 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral I	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII		Nas Decedent of Yes, specify Co		l? (Specify Yes or No Puerto Rican, etc.)	14. Race Blac Specify	k, White,	can Indian, etc. Asian
121 within	than he Me	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4gr 5+)	(Give life. l	dent's Usual Occ kind of work dor DO NOT use reti	ne during most o red)		16b. Kind of Bu		ment Defense
be file tal Hy	ent,	To Be Co	17. Father's Name (First, Middle, Last) Sing Hum				<del></del>	Name (First, Middle			
	1 27 is ma er trauma		19a. Informant's Name/Relationship (Type Jean B. Hum -wife	oe. Print)				or Rural Route Numb llege Park			
	ant: If item ury or othe		20a. Method of Disposition  1 ☐ Burial 22 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		emeterv. crei	sition (Name of matory or other p tan Cret	natory 1	Date 10/12/2007	20c. Location -	•	own, State Virginia
Balt permit. Depart	Important: If i any injury or once.		21. Signature of Funeral Service Licen	Junus 1	Ď 44	onald V 00 Powd	ressof Facility Borgwa er Mill	erdt Funer Road Belt	al Home, sville,	PA Mary	land 20705
	sician edical	0	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Cerebrovasc	ular I		-	rdiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
W 45	physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	uence of):						
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<b>□</b> pat	s been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.		tobacco use conti Yes 2□ No		he cause of death? bably 4 Unknown
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On Influence	vr: After thi ne funeral o	ation: T	27. Manner of Death  14 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	l v	juryat /ork? □Yes 2□No		how injury occurr	ed	
Division tal or Attending 's after death.	To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, offic	e	28f. Location City or To	Street and Numb wn, State)	er or Run	al Route Number,
Div To the Hospital or within 24 hours afte	he Funer pletely fill	ledical		ician: To the best of my knowner: On the basis of examination and manner stated.							
-	To t	M	29b. Signature and title of certifier	O well	友	29c. Lice D23	nse number 743		29d. Date signed Octobe		Day, Year) ), 2007
	e (		30. Name and address of person who con Martin Weltz, M.D.				e,#205 (	Greenbelt,	Marylar	nd 20	770
	Sta Registr		31. Date filed (Month, Day, Year) 0CT 12 200	32 Jegistrar's Signa	ture	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Physician Barksdale 11:56 P<sup>M</sup> Lee Redd Hoopes October 06, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6433 Wistasset Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2XF 82 Director 225-26-8742 24, 1925 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 6433 Wistasset Road 20816 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Completed by Specify. 3 Widowed 4 Divorced White Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natulary or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 2 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Barksdale Tza Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr Roy H. Hoopes / Spouse 6433 Wistasset Road, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metropolitan Crematory10/11/2007 | Alexandria, VA 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cuse (Final disease or condition resulting in death) Physician Non Small Cell Lung Cancer 10 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2X No Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s nas autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

State Registrar

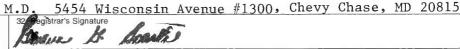
31. Date filed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barr,

29b. Signature and title of certifier

Frederick G.



29c, License number

D22775

29d. Date signed (Month, Day, Year)

10/09/2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#29dperMD10/12/07, BMW, MbCb Certificate of Death Date of Death Month Decedent's Name (First, Middle, Last) Ε. **Physician** Lena Hohmann 2007 October 10. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 7037 Sulky Lane 8. Date of Birth (Month, Day, Year Feb. 7, 1927 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Sweden 80 Feb. 579-58-1463 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XX No Directo Montgomery Rockville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20852 7037 Sulky Lane filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2K Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 5+ Medical Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Greta Enwall Ivar Norrlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 7037 Sulky Lane, Rockville, MD 20852 John R. Hohmann/Husband t of Heal: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or Metropolitan Crematory Alexandria, Virginia 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Francis of Address I fragilit Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. I to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pa **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause End of carry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 2 ∏ No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions Division or Vital Records, <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1∐ Yes 26. Place of Death (Check only one Be 25. Was case referred to medical Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 Inatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation.

State Registrar

Medical

29a. Certifler

29b. Signature and title of dertifie

31. Date filed (Month, Day,

Year

2007

DHMH 17 Rev 1/2001

egištrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, 2007)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct 9,2007 Physician Jeane I. Hofheimer 8:55pm /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death  ${\tt Potomac}$ **Examiner** Manor Care Potomac 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
June 29,1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Wash DC 227-12-6035 1 □ M 2 💢 F 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at ance. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Potomac 1 ZYes 2 No Director Montgomery 10e. Street and Number 10f. Zip Code 20854 10g. Citizen of What Country? United States 10714 Potomac Tennis Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2**∑** No þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William G. Illch Ruth Levy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6119 Ramsgate Rd, Bethesda, MD 20817 Gil Hofheimer/ Son 20b. Place of Disposition (Name of Park cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Wash Hebrew Memorial | 10-12-07 Washington DC 4 Donation 5 Other (Specify) 22. Name and Address of FacilityJoseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Multiple Sclerosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hyperlipidemia Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hour after death.

To the Funeral Director After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hypertriglyceridemia Due to (or as a consequence of): Urine Incontinence Physician/Medical IF FFMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**K** No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,

Kirti Vohra MD 7710 Bradley Blvd. Bethesda, MD 20817 31. Date filed (Month, Day, Year) State OCT 2007 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



and manner stated.

29c. License number

D-20274

29d. Date signed (Month, Day, Year)

10/09/2007

2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Markaal Examiner must be notified at once.

Saltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

burial-tran physician as the use for To the Hospital or Attending Physician: the funeral director. this after death.

Director; After t

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2007 11:09AM October 8, Edwin Hackley 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 01ney Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Min. Days Hours 1 € M 2 🗆 F Months 89 577-38-7830 Oct. 8,1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Director Md. Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20815 U.S.A. 6116 Western Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 TXYes 2 No1939— If Yes, Give Year or Dates: 1945 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: þ white 3 ☑ Widowed 4 ☐ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Marriott Corporation Auditor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornelius "Sam" Hackley Rorabaugh Anna ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16917 Vine Ct. Olney, Maryland 20832 Pamela Howton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Silver Spring, Md. Gate of Heaven 21. Signature of Pineral Service Licen 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W.Wash.D.C.20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 30 MINUTES thmi Atherocurate 10 YEARS Cardiovoscula-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an perform 2 No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M. D October 8:2007 D0058770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jevery Graf 18101 Prince Philip Price Olney, Mary lond strar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

within 24 hours a To the Funeral I

Amended Part II, nls, per phy., 10/19/07 A11

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0 07

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October 14, 2007

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Exami Funeral		Garrett County 5. Social Security Number 6. Se	Memorial Hoz	birthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. 8. [	Date of Birth Month, Day, Yea 1 - 1 9 2 4	r) Coui	place (State or Foreign ntry) 1 D
Director		219 14 5219 Usual Residence of Decedent	M 2 pp F 8 3			-1-172-		10d. Inside City Limits
Maryland -f show	tor	10a. State 10b. County  MD Garreta		own or Location Land				1 X Yes 2 No
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ath wi	ral	706 E. Alder Sa		21550	onanio Origin? (Specify	Ves or No-	USA 14. Race - Ameri	can Indian,
ING 2.12.13-UU3D be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or Items 23a or 28e-1 show event, the Mudical Exeminer must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	Specify:	an, etc.)	Black, White, etc.  Specify: White	
Maryland 21215-UU30 d 2 should be filed within 72 hours all th and Mental Hygiene. 77 is marked other then "neturel", or traumatic event, the Mudical Exemi	Completed I	15. Decedent's Ed (Specify only highest gra	ucation 1	6a. Decedent's Usual Occupa (Give kind of work done d life, DO NOT use retired,	luring most of working	16b.	Kind of Business/Ir	ndustry
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	2	Clyde E. Stah	man	19b. Mailing Address (Street a	Waneta V	Clar oute Number, Cit	y or Town, State, Z	ip Code)
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Page Page ment o		1 M Burial 2 □ Cremation 3 M 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification Specification Specifi	Pon.	ton Cometen 22. Name and Address	y 10-18	-2007	Hyndran,	PA
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other		21. Signature of Funeral Service Licer	V. KIEUW	Home 169	Clarence	St. H	Zeigler undman.	PA 15545 Approximate
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To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and marries states.	29c. Licens	se number	29d.	. Date signed (Moni	th, Day, Year)

nes State Registrar

Walter K.Naumann, M.D., POBox 247, Accident MD 21520

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 31. Date filed (Month, Day, Year) 0C1 1 8 2007

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		T - State Registrar		С	ertificate of	Death		Reg. No. 2	107	34468
Physic	ian	Decedent's Name (First, Middle, Last)					Date of De Month	Day	Year	3. Time of Death
/Medi		FRED EUKYLE	HELTON		1		OCTOB			00:23 A <sup>M</sup>
Exami	ner	4a. Facility Name (If not institution, give s  Anne Arundel Medi			4b. City, Town,		Death	4c. Count	of Death Arur	nde l
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Funeral Director			M 2□F	74 Yrs	Months   Davs	Hours I	Min. (Month, Da		Coun	lace (State or Foreign stry) nessee
		Usual Residence of Decedent								
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ath w	ra	5602 Carroll Stre				20733			ed St	
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d 21215-0036  filed within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-f show out, the Medical Examiner must be notified at	oy F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	Korean	1 ☐ Yes 2 🗷 No	Specify:		Speci	y: Wh	nite
21215-0036 ed within 72 hours aft giene. er than "natural", or t, the Medical Exami	Completed by	15. Decedent's Edu	cation	16a. De	cedent's Usual Occu	upation		16b. Kind of E	lusiness/Ind	dustry
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Vlai	은	Reuben Helton				Na	ncy Jan	e McDa	aniel	
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and and lealth m 27		Betty Mae Helton	\ MITE			1 50.,				
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	0 . 1		Muriel Muriel	ress of Facility H. Barb	er Funera	l Home	M.T. (	20002
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STIVA		30. Name and address of person who con Douglas Mite	ompleted cause of	death (Item 23a) (Ty	real Par	KWAY	Annapo	lis, mo	1 2	1401
Si Regis	ate	31. Date filed (Month, Day, Year)  OCT 1 5 20	32. egis	death (Item 23a) (Ty OO ( Mec) trar's Signature	Sporte	7	F	<u> </u>		
		001 1 0 20		1						

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 9 Day 2007 7:45 P Donald Edward Jamison 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) Feb. 17,1931 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Hours Days Months 1 X M 2 □ F Florida 267-40-1744 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Crofton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 1552 Farlow Ave. 21114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer NASA U.S. Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Mae Tweedle Samuel Edward Jamison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD. 1552 Farlow Ave. Malingna Jamison / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan crematory 10/12/2007 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Beall Funeral Home 20715 Bowie, MD. 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a o sequence of): hulmonay Intilliates Bilateal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 □Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner?

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

r 28a-f show notifled at

"natural", or Items 23a or dical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or item any injury or other traumatic event, the Medical Francis

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be

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death with the Maryland

physician and strans attending pl signed by the a this

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Be P

Completed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: / Medical State

Certification:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

1 Yes 2X No

5 ☐ Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certified

4605

29d. Date signed (Month, Day, Year) 12/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

| Type, Print) | PETK, MD 201 | Medical Punkway

31. Date filed (Month, Day, Year)

32. Registrar's Signature



Registrar

07-08194 Michael Barry Klei	'n	Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental H		gible.			
	1 F	1- For State Certificate of Death		eg. No. 20	07 3447		
Physician Medical Examine	-	1. Decedent's Name (First, Middle,Last)  Michael Barry Klein	Month October 2	Day Year	0752 hrs		
1		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th		
`\		9120 Georgia Avenue Silver Spring		Montgomery			
Funeral Director		5. Social Security Number 578-64-5932  1 X M 2 F F 7. Age (In yrs. last birthday)	1.	th(MM/DD/YYYY) 9. E Fore 27, 1950			
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
ě .,	1	Maryland Montgomery Silver Spring			1 Yes 2 X No		
Mary r 28a-	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?		
inh the		9120 Georgia Avenue 20910  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	necify Yes or No	USA 14 Race - Am	erican Indian, Black,		
ath wi	Funerai	1 Never Married 2 x Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	STOOT HOW, DOON		
fler de		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: or Dates:		Specify: Wh:	ite		
ours a	a D	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re		16b. Kind of Busines	s/Industry		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f she injury or other trannatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Lighting Designe		Enginee	ring		
5-0036 iled within 77 Hygiene. I other than the Medical		The state of the first three of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	ame (First, Middle, Maiden Surname)				
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and 2 and 2 Health item 2	H	Debra Klein/Wife 9120 Georgia Avenue.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.			or Town, State		
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altimore, rmit. Pages 1 ar partment of Hes portant: If ite jury or other ir	가	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Eacilly in Francis Colly in	2007	al Home Inc	-		
Der Der Inju		(Junior Sity B1	Silver Spr	ing, MD 20901			
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and		
xaminer	İ	Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic cardiovascular disease  Due to (or as a consequence of):			Death		
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	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
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	<u>a</u>	d					
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th cert trendir truse a	ပေ၊	past 12 months?  4 Pregnant at time of death 5 Other (Specify)					
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		25. Was case referred to medical 26.Place of Death (Chec		2 No 1 🗸	Yes 2 No		
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To wit To con	ĕ∣	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (			
5		Califold O.C.M.E.		October 21, 2	007		
	ł	30. Name and address of person who completed cause of death (tem 23a)	14004				
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201				
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	Physicia /Medic		Philip E. Kelley										7 12:00 a M
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	rrytan show		10a. State 10b. County		10c. City, Town		tion						10d. Inside City Limits 1√2Yes 2 □ No
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Funera Directo

Baltimore, Maryland 21215-0036

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Sta Registr	

	For State of N  1 - State Registrar		partment of H <i>ertificate of L</i>		-	^ ^	07	31.1.72
6	Decedent's Name (First, Middle, Last)				2. Date of De	- 400	UI	3. Time of Death
ian	Walter Kocopi				Month 10/9	3/2007	Year	
ical	4a. Facility Name (If not institution, give street and number	-)	4b. City, Town, or	Location of Dea		4c. County	of Death	9:10pm <sup>™</sup>
ner	Crofton Convalescent Cente		Croft		•••	1	Arun	do1
		ge (In yrs. last birthdi		If Under 24 Hr	s. 8. Date of Bir	th		lace (State or Foreign
	182-18-2763 <sup>1⊠M 2□F</sup>	90 <sub>Yrs</sub>	Months Days	Hours Min	8/16/	ı <i>y, Year)</i>   <b>917</b>	PA	try)
	Usual Residence of Decedent				0,20,2		111	
	10a. State 10b. County	10c. City, Town or					10	0d. Inside City Limits
ţ	MD Anne Arundel	Ode	nton					1 ☐Yes XXNo
Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	try?
O	565 Rita Dr.		2	21113			USA	
Funeral	11. Marital Status 12. Was Deceden	t Ever in U.S. 1	Was Decedent of Hi     If Yes, specify Cuba	spanic Origin? (	Specify Yes or No	)- 14. Rac	e - America	
F	Armed Forces  1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give	? INo 36-		n, Mexican, Pue	erto Rican, etc.)	Blac	ck, White,	
by	3 ☑ Widowed 4 ☐ Divorced If Ƴes, Give Year or Dates:	67	1 ☐ Yes 2 🙀 No	Specify:		Specif	v: Wh	ite
ted	15. Decedent's Education	16a, De	cedent's Usual Occupa	ation		16b. Kind of B	usiness/Inc	lustry
ble	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+)	ive kind of work done d e. DO NOT use retired,	luring most of we )	orking			
E O	12	,	Sergeant			US A	rmy	
Se C	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle	, Maiden Surnar	ne)	
To Be Completed	Harry Kocopi			Rose	Tchurz			
-	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street a	and Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code)
	Margie Hammond Daughter	464	Monterey A	ve. O	denton,M	D 2111	3	
	20a. Method of Disposition	20b. Place of Dis	sposition (Name of crematory or other place		Date	20c. Location		wn, State
	1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Ci			10/2007	Baltime	ore. 1	MD
	21. Signature of Funeral Service (See see		22. Name and Addres				-	
	17 / h		12 Ridgely		Annapoli			, P.A.
0.1	23a Part 1 Inter the Wassa or sharlingtions that cause	d the death. Do not					1401	Approximate
	23a. Part1. Inter the divease, or ion plications that cause shock, or heart flure. List iff y one cause on each				4	mest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	emic	Carolio	myo	pati	hy	•	years
	Due to (or as	s a consequence of):	Cardio	J	1			J
L.	Sequentially list conditions. b.	21000	Can	er				years
ine	Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence or):						<b>S</b>
Examiner	triat initiated events							
<u> </u>	Due to (or as	s a consequence of):					1	
edical	d							
	IF FEMALE:							
an/		2 Fetal death	3 □Ectopic pregnancy				te of delive onth	ry Day Year
sici	1 Yes 2 No 4 Pregnant a	at time of death	5 Other (specify)			IVIC	71101	Day Teal
hy	9 LI ORKHOWN							
by Physician/M	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause give	n in Part I.				e cause of death?
ed					. 10	Yes 2 No	3 ☐ Prob	ably 4 ∐Unknown
Completed					24a. Was	an 24b.	Were auto	psy findings available
E 0					- auto perfo 1⊟ Yes	ormed?	death?	npletion of cause of 2 ☐ No
Be C	25. Was case referred to medical			26. Place of De	eath (Check only		10,163	20110
To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outpat	tient 3 DOA Othe	r . /	Home 5 ☐ Resi		er (Spacifi	d)
٦	27. Manner of Death 28a. Date of Inj	ury 28b. Time	e of 28c. Injury			how injury occur		·/
ţ	1 Natural 5 □ Pending (Month, D. 2 □ Accident investigation	ay Year) Injur		:? /es 2 ☐ No				
lica	3 Suicide 6 Could not be 28e. Place of in	jury - At home, farm,	street, factory, office		28f. Location (	Street and Numb	er or Rura	l Route Number.
erti	4 ☐ Homicide determined building, e	tc. (Specify)			City or To			
C	29a. Certifier 1X Certifying Physician: To the besi	t of my knowledge, de	eath occurred at the time	ne, date and plac	ce, and due to the	cause(s) and m	anner as st	ated.
Medical Certification:	(Check only and manner s	of examination and/o	r investigation, in my or	oinion, death oc	curred at the time	date and place,	and due to	the cause(s)
Me	29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month.	Day, Year)
)	Karkesh and	101 MI	7	2010	2	10	1101	07
1				-010	0	- 1	1	/
	30. Name and address of person who completed cause of Rakesh Arora 14300		e, Print) Fox Lane	Bowie	MD 207	15		
		rar's Signature	LON Dane	POMTG	11D 201	1 3		
ate rar	OCT 1 1 2007		beeles					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND TITEM 10 Cherry 102 Person of Health and Mental Hygiene.

34473 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** FRANCIS MARION LEE 4:35 PM 18, 2007 Oct. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner DEVLIN MANOR NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex Funeral Hours Months Days MARYLAND X□M 2□F Yrs 218-16-4230 Director 83 12, 1924 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "netural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner mast be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD ALLEGANY 15405 WESTWOOD ROAD CUMBERLAND 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 15405 WESTWOOD ROAD 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give WWII Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **GUARD** DEFENSE 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES LEWIS LEE BLANCHE E. (JOHNSTON) LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SOMERSET, PA RICKI L. WOLK FOSTER SON 2799 WATER LEVEL RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Department o important: If any injury or REST LAWN MEMORIAL PARK OCT 24 07 LAVALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HAFER FUNERAL SERVICE, PA 1302 NATIONAL HWY., LAVALE, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Parti. Enter the disease shool or heart failure. I **Physician** Immediate Cause (Final disease or condition resulting in death) /iviedicar **Examiner** Due to (or as/a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician end for use es the buriaf-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? been signed by the a should be detached 1 → Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has the director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐Nursing Home 5☐ Residence 6☐Other (Specify) ۲ 1 Yes 2 No this 28c. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1-Natural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Hospitai 29a. Certifier 1 🖵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certified 700617565 19 2007 3 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) LaVare TID

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Registrar's Signature

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State Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08210 State of Maryland / Department of Health and Mental Hygiene Bernard Gerard Lager Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day
October 21, 2007 2251 hrs Bernard Gerard Lager al Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick **Frederick** Frederick Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Foreign Pennsylvania Aug. 27, 1953 Min. Months Days Hours 1 X M 2 54 181-38-9934 Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b, County 1 Yes 2 X No Frederick Frederick Maryland items 23a or 28a-f show ust be notified at once. with the Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Numbe U.S.A. 21701 9323 Hillsborough Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Armed Forces? 1 Never Married t: If item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner must <sub>Specify:</sub> White 2 Yes Yes 2 X No specify: Divorced If Yes, Give Year Widowed ۾ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Computers Software Test Manager marked other than more, MD 21215-0036
Pages I and 2 should be filed within 7:
nent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Jeanne Burkholder Bernard G. Lager Be 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9323 Hillsborough Drive, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print)
Mrs. Gretchen Lager, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, Burial 2 X Cremation 3 Removal from State Smithsburg Crematory Oct. 24, 2007 Smithsburg, MD Important: onation Other Specify: 21. Si ture of useral Service idenser 22 Reemey and Basford PA Funeral 106 East Church St., Frederick, MO0255 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Driset and Physician failure. List only one cause on earh line Medical Phentermine and Diphenhydramine intoxication Immediate Cause (Final disease \_xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical e attending physician a for use as the burial -X UNPENDED 28a-f. perME, g873, 11/1/07 TI The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown <u>გ</u> 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury ne Hospital or Attending Ph n 24 hours after death. he Funeral Director: After 27. Manner of Death After Certification: 1 Yes 2 x No Natural Pending Fnd 10/21/2007 Fnd 9:35 pm the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 9323 Hillsboro Dr. Frederick, MD Suicide determined (Specify) Residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 22, 2007 O.C.M.E. my 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 2 6

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	Dhusisi		1. Decedent's Name (First, Middle, L	ast)	116/-			_	2. Date of Month	Death Day	Year	3. Time of	Death
	Physici /Medio		Sven-Otto Ljur	ngholm						mber 2	29, 2007		a <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, g				4b. City, Town, or	Location of D	eath	4c.	County of Death	h	
			Holy Cross Hosp 5. Social Security Number 6.		(In yrs. last bi	inthoda ( )	Silver If Under 1 Year		Hrs. 8. Date of		Iontgome	ery	r Foreign
п	Funeral Director		None	1⊠M 2□F		Yrs.	Months Days	Hours N		Day, Year)	Co	un <i>try)</i> ryland	rroreigir
			Usual Residence of Decedent					14.	JJ bept.	20, 2	007 Ha.	Lyrand	
	how		10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside Cit	-
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	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Co		
	a 23a		611 Tammy Terrac			40.1	20175		2 /2	N-	United  14. Race - Ame		
	item de	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 N		13. V	Vas Decedent of Hi Yes, specify Cuba	in, Mexican, P	r (Specify Yes or Juerto Rican, etc.)	No-	Black, White		
930	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Other than "natural", or itema 23a or 28a-f show other than "natural", or itema 24a or 28a-f show event, the Medical Examiner must be outlifted a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2X No	Specify:			Specify: V	Vhite	
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ž	hould d Mer mark mark	ပ္	Sven-Goran Delma  19a. Informant's Name/Relationship			h Mailin	g Address (Street a	Tany		mbor City o	Tour State 7	Zin Codo)	
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Baltimore, Maryland 21215-0036	Pages ent of nt: If i		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			•	natory or other plac Ln Cremat	. 1	/15/2007	Bre	entwood,	Marv1:	and
<b>=</b>	mit. F partmi portar i injur		21. Signature of Funeral Service Dic		10. 11		. Name and Addres		Simple			itary	arid
m	permit. Pages 1 and 2 should be Department of Heatils and Menia Important: If Item 27 is marked eny injury or other traumatic evonce.		DUS. (A			10	40 Rockv	ille P				Land 208	852
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do							Approximate Interval Bet	9
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Box	leath certifics attending pl	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy						23d. Date of deli	ivery	
m	death e atten	icia	in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other (specify)			_	Month	Day 1	/ear
Q.	at the de by the stached	Physician/Me	9 Unknown	9⊡ Unknown									
S.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death bu	it not resulting	in the ur	derlying cause give	en in Part I.	23e. D	id tobacco u	se contribute to	the cause of d	eath?
Division of Vital Records,	w require been sign	ted							_ 1	☐ Yes 2	⊠No 3∏Pr	obably 4 □L	Inknown
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<u> </u>	: The law cate has page 2 :	Completed							P	erformed? s 2 🔯 No	death?	2□ No	
<u> </u>	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	- Hannitali			100		Death Check on	ly one)			
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2		Certification:	4 ☐ Homicide determine	building, etc.	. (Specify)		,,,			Town, State			
	Hospital or     A hours afte     Funeral Directletely filled in 1		29a. Certifier 1 Certifying I	Physicien: To the best o	f my knowledg	e, death	occurred at the tim	ne, date and p	place, and due to	he cause(s)	and manner as	stated.	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai	(Check only 2 Medical Ex-	aminer: On the basis of and manner stat	examination a ted.	na/or inv	estigation, in my of	pinion, death o	occurred at the tin	ne, date and	place, and due	to the cause(s	)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1\			29c. License	e number			e signed (Monti		
			100	- C.	3.		D53.	509		09	/29/200	7	
			30. Name and address of person wh				<i>'</i>						
		Ш	Janel K. Hino. 31. Date filed (Month, Day, Year)	22 Angietra	r'e Signature		en Rd; S	ilver S	Spring, 1	MD 209	10		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/AMEND#5per/FH10/17/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 10, 2007 Physician 10:40 P M Ronald Joseph Long /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 12032 Winding Creek Way Germantown If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 5, 1972 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 216588W7783 **35** Days Hours 1 X M 2 □ F <del>218 88 7783</del> Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unit. If Item 27 is marked other than "natural", or items 23b or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 3a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10b. County 1 □Yes 217 No Maryland Montgomery Germantown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 12032 Winding Creek Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ∏Yes 2 No fYes, Give 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry or than "y Elementary/Secondary (0-12) College (1-4or 5+) 2 Photographer Photography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth E. Long Barbara O. Bull ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert T. Long (Brother) 24241 Parker Road, Georgetown, DE 19947 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot October 11 emetery crematory or other place)
Metropolitan 1 ☐ Buriat 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2007 Alexandria, Virginia Crematory 21. Signature of Funeral Service Lio 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Env. the seas, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, of healt billure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Capse Final disease or condition resulting in this Coronary Artery Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of mild.) that initiated events resulting in death) Last Due to (or as a consequence of): Exami physician and s the burial-tran Due to (or as a consequence of): Physician/Medical as attending | IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No ed by the detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 9 History of Myocardial Infarction and 1 ☐ Yes 2 ☐ No 3 🎇 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Ventricular Tachyarrhythmia 24a. Was an page 2 has autopsy performe 2 No 1 Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

certificate be executed P.O. Box 68760 Division or Vital Records, Physician:

altimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

D56345

29b. Signature and title of certifier

2007

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

October 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piyush K. Patel, M.D. 19745 Executive Park Circle, Germantown, MD 20875 31. Date filed (Month, Day, Year) OCT 12

State Registrar

Medical

		1 - For State Registrar	Stat	e of Maryla	nd / Depa	artme <i>rtifica</i>	nt of H	ealth a	and M		gienez	007	344	177
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/Medic Examin		4a. Fecility Name (If not institution				4b. Cit	y, Town, or	Location of				County of Deat		
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Funeral		Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Und	ler 1 Year	If Under	24 Hrs.	8. Date of Birth	1			r Foreia
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		30. Name and address of person	who completed	cause of death (It	em 23a) (Type,	Print)								
		Janel K. Hin	o, M.D.	1500 F	orest 6	Glen	Road.	Sil.	ver 9	Spring,	MD 2	20910		
Sta	te	31. Date filed (Month, Day, Year	2007	32 Registrar's Sig	nature									
Registr	ar	UCT 12	2007	SAME	K do	sale!	7							

# altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, as for use certificate funeral director, After this

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** DUANE HARRY LANTZ 10 07 2320 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 78 213-24-7260 Director West Virginia 06/28/1929 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 No Director WV Mineral Ridgeley 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number "natural", or items 23a or adical Examiner must be Route 1 Box 204A 26753 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after rarment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natural", or ite niluty or other traumatic event, the Medical Examinent. 1 X Yes 2 No 1951— If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: <u>Ş</u> 3 Widowed 4 Divorced 1954 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Foreman Tire and Rubber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roscoe Dewey Lantz Marguerite Belle Day ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LuCinda Witt/ Daughter 12126 Moore's Drive, LaVale, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or Restlawn Mem. Gardens 10/22/2007 LaVale, 21. Signature of Foneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home. 6 404 Decatur Street, Cumberland, MD 21502 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1AY AICOMUSA disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physiclan and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) as been signed by the 2 should be detached 9☐Unknown 9 Unknown Partyl. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ INTAR 1 Tyes 3☐ No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🥦 No မှ 1 Dinpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of cert fier 29c. License number 29d. Date signed (Month, Day, Year) 1035ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) umberland m nes Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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and 2 ealth a n 27 is		Marguerite Matovich Wife 2001	Buckeystown Pike	Buckeysto	own, MD 21717
Pages 1. nent of He int: If Iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Kee	eney & Bas	sford P.A. F.H.
		23a. Party Enter the disease, or complications that caused the death. Do not en enock, or heart failure. List only one cause on each line.	106 East Church St		
Physician		effock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.	n Pneunonia Bowel OL		Approximate Interval Between Onset and Death
/Medical Examiner		Oue to for as a consequence of):	11 p 1 M	1 - 4	
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Down OL	Swell	on with
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tendlineath.	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
lor At after d Direct	Certification:	4 Homicide determined determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
		Auto	D26516	8	cTober 222007
641		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	11/10	CTOBER 222007
() (	ate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	THE TREDER	CAS MI	0 21402
Regist		OCT 2 5 2007 Diseas & p	had o		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May OCTOBER 18, Lillian 2007 17:12 Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/06/1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 93 219-46-0063 Maryĺand Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 1 √ Yes 2 □ No Director MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? USA 534 Princeton Street 21502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental h Be Belle Runion Frank Casper Sager Anna ို permit. Pages 1 and 2 sh.
Department of Health and Important: If item 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Kirchner / Daughter 901 Braddock Road, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) S.S. Peter & Paul Cem. 10/22/2007 Cumberland, MD 21. Signatur of Juneral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 alus 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oroNal Dyears disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe this certificate 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 D33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MAS

State

GUPTA, \_\_ 31. Date filed (Month, Day,

SUNIL K., M.D.

SUITE 101, CUMBERLAND, MD 21502

625 KENT AVENUE,

Registrar's Signature

		1 - State Amend Item 3 1 - Registrar 1 Decedent's Name (First, Middle, Last	)		Departme 1/05/07 Centrica	nt of Headhb te of De	alth and N eath	/lental Hy			34482 3. Time of Death
Physici /Medio Examin	cal	Lorraine Cec  4a. Facility Name (If not institution, give  Asbury-Solomons	street and number)	uers Care			ocation of Death	Oct 1	2 4c	2007 County of Death	4:20 p. <sup>™</sup>
Funeral Director		5. Social Security Number 6. Se 577–60–0333 Usual Residence of Decedent	M 25xF 93		Yrs. Month		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 30	ı <i>y, Year)</i>	9. Birthp Cour 14 Minr	place (State or Foreign ntry) nesota
death with the Maryland ome 23e or 28e-f ehow r must be notified at	ector	Maryland Calvert  10e. Street and Number	1	oc. City, Tow Solomon		Lip Code			100 Cit	tizen of What Cour	1 ☐ Yes 2√ No
th with	a Di	514 Aldersgate			1	0688			_	ted State	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hyglene.  Deperment of Health and Mental Hyglene.  Deperment of Health and Mental Hyglene.  Proportent: If them 27 is marked other than "naturel; or Iteme 23e or 28e-f show eny injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	er in U.S.		_	anic Origin? (Sp Mexican, Puerto Specity:	pecify Yes or No Rican, etc.)	)-	14. Race - Americ Black, White, Specify: W	
within 72 ho ane. then "natur ne Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			Decedent's Us (Give kind of v life. DO NOT sistant	vork done dur use retired)	ing most of work	_		aral Gove	
uld be filed Aental Hygie rked other tic event, it	To Be Co	17. Father's Name (First, Middle, Last) Anthony Edward M	euers	AS	SISCAIIC	18	Rose De.	e (First, Middle		Sumame)	CITINCITE
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Pages 1 ament of He ent: If Item ury or oth		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 🝱  4 □ Donation 5 □ Other (Specify)	Removal from State		f Disposition (A ry, crematory of Hope Ce	metery	Oct 18	Date 8 2007 (		ocation - City or To on Arizo	
permit. Departimporti eny Inj		21. Signature of Funeral Service Licens				and Address on 600	of Facility Rate Lusby,	usch Fu MD 206		1 Home	
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.  a	0/	OP	ode of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
ding Physicien: The law requires that the death certificate be executed.  In.  Inter this certificate has been signed by the ettending physicien and tuneral director, page 2 should be detached for use as the burial-transit.	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or as a of Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Du								
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equires that en signed b ould be deta	۵	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the underlying	cause given	in Part I.		obacco Yes 2		he cause of death? pably 4 Unknown
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Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 🗆 ER/O	utpatient 3□ [	Other	6. Place of Deat			C []Other (Care)	4.0
Attending Phy ir death. ector: After this by the funeral d	atlon; To	27. Manner of Death  ★■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day )	28b.	Time of Injury	28c. Injury at Work?		28d. Describe		6 ∐Other (Specifing occurred	<i>Y</i> /
	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specity)				City or To	wn, Stat		
To the Hospital or within 24 hours afte within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exami	sician: To the best of e ner: On the basis of e and manner state	camination ar	e, death occurre nd/or investigation	d at the time, on, in my opin	date and place, ion, death occur	and due to the red at the time,	date an	d place, and due to	o the cause(s)
To t To t	Σ	29b. Signature and title of certifier	9, MS			9c. License n	umber 17/53		29d. Da	to be 1/5	Day, Year)
20		ERIC BELG M	IIO \$	th (tem 23a)	(Type, Print)	Rosa	PRIN	ce Fre	tee	ck. Mi	20678
Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	Signature	K do	and s				1	

			For State Registrar	State of Ma	aryland	-	artment of rtificate of	Health and	Mental Hy	giene		01100
		61	1. Decedent's Name (First, Middle, La	st)	-				2. Date of D	eath	2001	3. Time of Death
	Physici /Medi		ANNIE JEAN MA	ASSEY					Month OCT.	Day 9	2007	11:00A M
	Examir		4a. Facility Name (If not institution, giv	,			4b. City, Town,	or Location of Deat	1		County of Death	
			4906 MEADOWBRO	OK DRIVE			SUITLA			PF	RINCE GI	
	Funeral Director		13 40-3303	1	e (In yrs. la 6 l	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D JUNE	rth ay, Year) 19,	9. Birthp Coun 1946 SO	lace (State or Foreign try) UTH CAROL
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation				1	UNA Od. Inside City Limits
	Marylan -f show fied at	tor	MD PRINCE	GEORGES	SI	JITLA	ND					1 Yes 2 No
	r 28a	Director	10e. Street and Number		l		10f. Zip Code			10g. Citi	izen of What Cour	itry?
	th wit	alD	4906 MEADOWB	ROOK DRIV	/E		2074	16		U	.S.A.	
	r dea ems	Funeral	11. Marital Status	12. Was Decedent in Armed Forces?	Ever in U.S	. 13.		Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or N o Rican, etc.)	0-	14. Race - Americ Black, White,	
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married XXMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 1  If Yes, Give  Year or Dates:	No		1⊡Yes XIN		,		Specify: BL	
5	72 h "natu dical	ete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece (Give	dent's Usual Occu kind of work done	upation e during most of wo ed)	king	16b. Ki	ind of Business/Ind	dustry
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pu	I.2 should be filed v n and Mental Hygie is marked other t raumatic event, th	Be (	17. Father's Name (First, Middle, Last					18. Mother's Nar	ne (First, Middle	e, Maiden	Surname)	
Maryland	should trud Ment marked umatic e	2	JULLIAN CALLA	HAN				ALBER	OHT ATS	MPS	ON	
Nar	2 short and raum		19a. Informant's Name/Relationship (	4000								*
	1 and Health em 27		MARION MASSEY/I	TLAN	ID, MD 20	0746						
Ö	iges if ite		20a. Method of Disposition  MBurial 2 □ Cremation 3 □				osition (Name of matory or other pl	1	Date	20c. Lo	ocation - City or To	own, State
Baltimore,	permit. Pages 1 a Department of Her Important: If Item any Injury or othe		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		FT.		COLN CE		15/07	BE	RENTWOOL	O, MD
Ba	permit. Departr Importa any Inj		21. Signature of Puneral Service Lice	Downart			2. Name and Addi 500 ALL	ENTINOLINI S	TRICKL	AND	FUNERAI	SERVICES
	47.078		23a. Part1. Enter 4. disease, 1r com shock, or heart failure. List nly	plications that caused	the death.			ring, such as cardia	or respiratory	MP S arrest,	PRINGS	MD 20748 Approximate Interval Between
	Physician /Medical Examiner		snock, or near failure. List nly Immediate Cause (Final disease or condition resulting in death)		STAT	IC O	VARIAN					Onset and Death
£1,	25 m	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Exa	that initiated events resulting in death) Last	CDue to (or as	a consequ	ence of):			-			
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.O. Box	that the death certifica hed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3E	⊒Ectopic pregnan ⊒ Other (specify)	су			23d. Date of delive Month	ery Day Year
Δ.	res that I		Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco u	use contribute to the	ne cause of death?
or Vital Records,	gr	d by							1 🗆	Yes 2	MNo 3□ Prob	pably 4 □Unknown
S	s been si s been si	Completed							24a. Wa	s an	24b. Were auto	psy findings available
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ta		Be C	25. Was case referred to medical					26. Place of De			1 □ Yes	2 No
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0	endlr ath. or: Af	atio	2 ☐ Accident investigation	ו	, , , ,			JYes 2 □ No				
Division	l or Attend after death Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of inju- building, et	ury - At hor c. <i>(Specify)</i>	ne, farm, sti )	reet, factory, office	9	28f. Location City or To	(Street an own, State	nd Number or Rura e)	al Route Number,
	Hospita 24 hours Funeral	Medical Co	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best niner: On the basis o and manner sta	f examinati	/ledge, deat on and/or ir	h occurred at the ovestigation, in my	time, date and place opinion, death occ	And due to the urred at the time	e cause(s e, date and	) and manner as s d place, and due t	tated. o the cause(s)
	within to the comple	M	29b. Signature and title of certifier	)			29c. Licer	nse number		29d. Da	te signed (Month,	Day, Year)
	(11)		· overfacto	are MD			D16	5619		OC!	TOBER 1	0, 2007
	Case		30. Name and add es of person who				,	MAT. DT.	#104 T			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
OCT 1 2 2007

			For State Registrar	CHRIKI	Trestate	-OIYVIZ	arylari ———		<del>partme</del> ertifica				lental H	ygien Reg. N		7	31.	1.81.
9:	Physicia /Medic		1. Decedent's Nam Mollie		e, Last)				Newm	an			2. Date of D Month Octobe	r 7,	2007 Ye	ar	3.4 ime o	O PA M
	Examin		4a. Facility Name (							kvil		of Death			c. County of E		<b>411</b>	
F	Funeral		Hebrew H. 5. Social Security		6. Sex	7. Ag		last birthda		er 1 Year		r 24 Hrs. Min.	8. Date of E	Birth Day Yea	9	Birthoia	ace (State	or Foreign
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yland	at		10a. State	10b. County			10c. City	y, Town or	Location						-	10	d. Inside C	City Limits
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with th	a or 2	Dire	10e. Street and Nu 6121 Mo		Road					ip Code 0852					Citizen of What	t Count	ry?	
<b>5-0036</b> 72 hours after death with the Maryland	Department of health and Mental Hygene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Man 3 ☑ Widowed	ried 2□ Mar	12. Was D Armed	Decedent I I Forces? es 2 🐼 I Give or Dates:		.S. 1		edent of H ecity Cuba	lispanic O an, Mexica Specify		ecify Yes or t Rican, etc.)		14. Race - A Black, V Specify:	Vhite, e		
<b>21215-0036</b> ed within 72 hours aff	sne. than "natu ne Medical	Completed	(Spe Elementary/Sect 12	cify only highe	nt's Education est grade complete Colleg	ed) je (1-4or 5	·+)	1	cedent's Us ive kind of w e. DO NOT nemake		ation during mo d)	st of work	ing	1	Kind of Busine		ustry	
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	ysician Medical		23a. Part T. Enter shock, or her Immediate Cause disease or condition resulting in death)	art failure. List (Final on	only one cause of	on each lir	ne. Nic C	ardio	enter the mo		ng, such a					_	Approxima Interval Be Onset and	ate etween I Death
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ords, P.	been signed by the s should be detached f	þ	Part II. Other sign	ificant conditi	ons contributing t	o death bu	ut not resi	ulting in the	e underlying	cause giv	en in Part	l.			o use contribu 2⊠No 3[			
al Records,	: certificate has be irector, page 2 sho	Completed											24a. Wa au pe 1∐ Yes	topsy rformed?	prio	r to com th?	osy findings npletion of 2  No	s available cause of
or Vita Physician:	certifi	Be C	25. Was case refe examiner? 1 ☐ Yes 2 ₹		Hospital:	□ Innatia		ER/Outpat	tient 3∏ □	OA Oth			h (Check onl		- 50			
C E	trn. r: After this e funeral di	ation: To	27. Manner of Dea 1 Natural 2 Accident		28a. D	ate of Injuried	ry	28b. Time Injur	e of	28c. Injur Wor	4 24 1				6 ☐Other ( jury occurred	Specity	)	
Divis	rs arrer dearn. rai Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern	singed 200. FI	ace of injudiced	ury - At ho	ome, farm,	street, facto	ory, office			28f. Location City or 7	(Street Town, Sta	and Number o	r Rural	Route Nu	mber,
he Hospital	within 24 hours a  To the Funeral C  completely filled	Medical	29a. Certifier (Check only one)	1 A Certifyli 2 Medical	ng Physician: To Examiner: On the and r	the best one basis of nanner sta	f examina	wledge, de ation and/o	eath occurre r investigatio	d at the tir	me, date a opinion, de	and place, eath occur	and due to the red at the time	ne cause ne, date a	(s) and manne and place, and	er as sta due to	ated. the cause	(s)
To the	To t	Σ	29b. Signature and	d title of certifie	CILIA	)				9c. Licens				29d. [	Date signed (A	Ionth, L	Day, Year)	
5			30. Name and add	lross of name	who completed	will all the	oath (lta-	n 23a) /T		D1808	34			110	19/07	-		
			Dinesh D					ose I		Rock	ville	e, MD	20852		• 1			
100	Sta Registr		31. Date filed (Mor	oth, Day, Year,	2007	2. Pogistra	ar's Signa	ature //	Cook	7								

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		For State		State o	of Ma	aryland		artment of I <i>rtificate of</i>	Health and	Mental Hy					
		Registrar  1. Decedent's Name	o (First Middle I	aet)			Cei	runcate or	Dealli	2. Date of D	Reg. No	· 20(	17	3 madi	48
Physicia /Medic			( , , , , , , , , , , , , , , , , , , ,	Willa M	ae l	Pack				Octobe		.8 200	7	0113	AM
Examin	er	4a. Facility Name (f	f not institution, g	ive street and nu	m <i>ber)</i>				or Location of Deat	h	40	c. County of D	eath		
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Funeral Director		5. Social Security N		Sex 1□M 2 <b>X</b> F	_		ast birthday) Yrs.	Months Days		(Month, D	ay, Year	)	Countr		
		221-26-99 Usual Residence of			6	/				April 2	0, 19	4U   WE	St	Virgi	nia
ryland how		10a. State	10b. County			10c. City	, Town or Lo	ocation					100	d. Inside Cit	
e Ma Ba-fs	Director	Maryland	Cecil	<u> </u>		E1	lkton							1 🗌 Yes	2 <b>K</b> No
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fter de ritem iner i	Fun	<ol> <li>Marital Status</li> <li>□ Never Marr</li> </ol>	ried 2X Married	Armed Fo	orces?				Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	10-	Black, W			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	3 Widowed		If Yes, Gi Year or D	ve -			1 ☐ Yes 2 🛣 No	Specify:			Specify:	Whi	.te	
"natu	lete	(Spec	15. Decedent's l cify only highest g	Education rade completed)			16a. Dece (Give	dent's Usual Occu	pation during most of world d)	rking	16b. I	Kind of Busine	ss/Indu	stry	
within ene. than	Completed	Elementary/Seco	ondary (0-12)	College (	1-4or 5	+)		shier	<i>≠u)</i>		[	Retail	S-1.	05	
filed Hygi other	ပို	17. Father's Name	(First, Middle, La	st)				311.01	18. Mother's Nar	me (First, Middle	<del></del>		Dar	<u> </u>	
fental fental rked iic ev	To Be	Basil T.	. Bolt						Helen D	. Sheav	es				
and N		19a. Informant's N	ame/Relationship	(Type. Print)			19b. Mailir	ng Address (Stree	t and Number or Re	ural Route Num	ber, City	or Town, Stat	e, Zip C	Code)	
and and m 27			. Pack/Ηι	ısband			51 P	leasant 1	Hill Dr.,						
ges 1 t of H if itel		20a. Method of Disp 1 Burial 2	position  Cremation 3	☐Removal from	State			osition (Name of matory or other pla	10000	ber 23,		Location - City			
t. Pa rtmen rtant: njury			5 Other (Spec			R.A.		s & Co., Ir				lest Ch	est	er, PA	1
perm Depa Impo any l		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hicks Home for Funerals, P											1	1 010	001
Chen		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arms sho k, or heart failure. List only one cause on each line.												Approximate Interval Betv	
Physician		immediate Cause	(Final					0-15		0 0-		~ (ccc),		Onset and D	eath
/Medical		disease or condition resulting in death)	on	a. Due to	(or as a	a consequ	ience of):	1 10 15 1	UMBNI	HAN	10	Chi-	-	1201	145
Examiner		Consortable list a	erditions.	IS	CZ	IEN	11C	CMP	UMONI	9 25	-3	0-1.			
p d	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying	Due to	(or as a	a consequ	ience of):			0					
be executed sician and burial-transit	хаш	that initiated events resulting in death)	s Last	c	(or as a	a consequ	lence of):								
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h cert ending	M	(F FEMALE: 23b. Was deceden		23c. If yes, ou		pf pregnar 2   Fetal		∃Ectopic pregnand	01			23d. Date of	deliver	y	
e deat	by Physician/Medic	in the past 12 1 ☐ Yes 2 {	Q/No		nant at	time of de		Other (specify)	Су			Month		Day Y	/ear
d by the	Phy	9 ☐ Unknown Part II. Other signi				it not room	lting in the u	ndorhina aguso ai	ivon in Port I	230 Did	tobacco	use contribut	n to the	oguso of de	oath?
ires ti signe	þ	CAT)	heart conditions	contributing to a	~	ما و	~~~ē	riderlying cadse gi	1-211-				Proba		Inknown
v requ	Completed	``	) /VY	7,00	1 1	1			AVO I E	24a. Wa		1			
he lav has ge 2 ;	dm	-15m	_, Uh	1-, 1-	1 p	M)	5	1- 4		aut	s an opsy formed?	prior	to com	sy findings a pletion of ca	
in: T ificate or, pa		25. Was case refer	rred to medical	· T					26. Place of Dea	1□ Yes	2/Z/N	io 1 🗆 '	es 2	2 □ No	
ysiciz s cert direct	To Be	examiner? 1 ☐ Yes 2 ☐		Hospital:	Inpatie	nt 2 ∏ E	ER/Outpatier	nt 3 DOA Ot	hor:	dome 5 ☐ Res		6 □Other /	Specify)		
ig Ph ter th	Ë	27. Manner of Deat	th 5 Pending	28a. Date	of Injur		28b. Time o	f 28c. Inju		28d. Describe			,,		
endir sath. or: Ai	atic	V <sub>2</sub> ☐ Accident	investigati	on					]Yes 2 □ No						
or Att after de Direct in by i	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine	d Zoe. Place	e of inju ling, etc	iry - At hoi c. (Specify	me, farm, str	reet, factory, office		28f. Location City or To	(Street a own, Sta	and Number o ite)	r Rural	Route Numi	ber,
		29a. Certifier	1 Certifying I	hysician: To the	e best o	of my knov	wledge, deat	h occurred at the	time, date and place	e, and due to th	e cause(	(s) and manne	r as sta	ted.	
he Ho In 24 I he Fu pletel	Medical	(Check only V	2∐ Medica! Ex	aminer: On the b	nasis of oner sta	examinat ited.	tion and/or in	ivestigation, in my	opinion, death occ	urred at the time	e, date a	nd place, and	due to	the cause(s	)
To t To t	Σ	29b. Signature and	title of certifier	4					se number			ate signed (M		ay, Year)	
		• //\	amilei	Their		~	D	20	0 637	30	10	11812	7		
ij		30. Name and add	ress of person wh						ELILTO	~ ~					
Sta	e	31. Date filed (Mon			-	ar's Signa			1210	- 11	<u>ٽ</u>				
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100	Physici		Decedent's Name (First, Middle, L  James Walke	,	Par	ker,	7				2. Date of Deat Month	h Day	Year	3. Time of Death
2000年	/Medi Examir		4a. Facility Name (If not institution, g	ve street and number	er)	Kel,	· ·		Location of I		October		2007 ounty of Death	12:52
	Funeral Director		Carriage Hill of 5. Social Security Number 6. 579-30-2005		Age (In yrs. 1	V		hesd r1 Year Days	If Under 24	Min.	B. Date of Birth (Month, Day,		9. Birth Cou	place (State or Foreign intry) Shington, D(
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  3800 Portman Pl  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced		ent Ever in U.		COLT 10f. Zij	2104 dent of Hi	2	n? (Spec Puerto R	ify Yes or No- ican, etc.)	14.	USA Race - Ameri Black, White,	ican Indian, , etc.
121215-0036	led within 72 hou lygiene. her than "natural it, the Medical Ex	Completed by	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	grade completed) (Giv   College (1-4or 5+)   Iiie.			DO NOT L	ork done d	during most o ) nce		Own			
Maryland	ould be fi Mental F arked otl	To Be	17. Father's Name (First, Middle, Las James Walker Pa	rker		T					First, Middle, N		rname)	
Baltimore, Mar	permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum one.		19a. Informant's Name/Relationship Robin Elizabeth  20a. Method of Disposition  1	Kokolis/Dana Sta	20b. P	3800 lace of Dispo emetery, crei	Port	man me of other place Cemo	Place,	E11 Oct	. 15,	City, 20c. Locat	MD 21	042 own, State
8760,	Physician /Medical Examiner physician and physician street prize the prize transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.Sepsis Due to (or b.Pneumon Due to (or	as a consequ	n. Do not ent uence of): uence of):	go on	IVer;	SITY B	STVC ,	W, Si-	Iver	Spring	Approximate Interval Between Onset and Death
9	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d	I. Date of deliv	very Day Year
ırds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions Metastatic Canc			ulting in the u	nderlying o	ause give	en in Part I.		23e. Did tob			the cause of death?
al Reco	ician: The law re certificate has be rector, page 2 sho	Completed									24a. Was ar autops perform 1 Yes 2	n 2 y ned? 2 🔀 No	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
<u>=</u>	siciar certifi irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	atient 2 🗆 1	ED/Outpotion	nt 3□ D0	Othe	ir.		Check only one		70	
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: T	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation of determined		28c. Injury Work 1 🔲 \	iry at 28d. Describe how injury occurred rk?  Yes 2 \[ \] No								
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying F	hysician: To the be miner: On the basis and manner	s of examinat	wledge, deatl tion and/or in	n occurred vestigation	at the tim	ne, date and pinion, death	place, ar	nd due to the ca	ause(s) an ate and pla	d manner as s	stated. to the cause(s)
}	Within To the Comp	Me	29b. Signature and title of certifler	Decum	1_		29	c. License	number	>6			igned (Month, er 11,	
	,		30. Name and address of person who Tipaporn Woodward	d, M.D	5530 W	iscons		venue	<b>,</b> #55	0,Ch	evy Cha	se, 1	MD 208	15
	Sta Benistr		31. Date filed (Month, Day, Year)		strar's Signa	H A	anti)	•						

State of Maryland / Department of Health and Mental Hygien & UU / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anri Petrosyan 11:50 P<sup>M</sup> 8 2007 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Marke Dave Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1♥M 2□F Yrs 213-41-6749 Director 71 Armenia Feb. 4, 1936 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28e-f ehov The Medical Examinar must be notified at 1 ☐ Yes 2 📉 No Director MD Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22008 Stone Pier Lane 20841 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Leather Goods C.E.O. Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, es 1 and 2 should be fill of Heelth and Mental H fitem 27 is marked ott Be Egesh Petrosyan Manush Martirosyan ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariya Petrosyan 22008 Stone Pier Lane, Boyds, MD 20841 Peges 1 rtment of F ortent: If it 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) October 13 All Souls Cemetery 2007 Germantown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hore 10 East Deer Park Drive, Gaithersburg, MD 20877 DeVol Funeral 23a. Part1. Intertransease, or complications that cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, british friture. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause Final disease or condition resulting in death) HRONIC OBSTRUCTIVE Physician /Medical Examiner ) CUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ettending physicien and for use as the burial-transit law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the et d be detached fo 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: at or Attending Patter death. 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft 29a. Certifier 1 Certifying Physician: To the bast of my knowledge ideath conumed at the time date and plane, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) POO 5386 2007 OCTOBER 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Silva M.D., Rockville, MD 20850 9715 Medical Center Drive #105

State Registrar 31. Date filed (Month, Day, Year) 2007 Sgistrar's Signature

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 Day **Physician** 9 7:30 A<sup>M</sup> 2007 James Arthur Pittman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1⊠M 2□F 1941 North Carolina June 22, Director 243-52-8046 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Ħ 1 ☐ Yes 2 No r 28a-f sh notified Director Adelphi Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or e death with items 23a iner must b USA 2709 Lackawanna Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. orces?

2 No
9-9-65

Nates: 2-17-70 Examiner within 72 hours after 1 XYes 2 If Yes, Give 1 Never Married 2 Married ь 1 ☐ Yes 21 No Maryland 21215-0036 Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) P and P Office Supply Owner yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be in and 2 should be fill Health and Mental Hem 27 is marked ot Lucille Pittman Fred Pittman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is 2709 Lackawanna Street, Adelphi, MD Pauline Pittman/Wife other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place George Washington Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō 10-15-2007 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. peral Service Licensee 21. Signa re of Fu 4217 9th Street, NW Washington, DC 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed use as the burial-trans Due to (or as a consequence of): Box 68760. ding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Gastro-esophageal Carcinoma 24a. Was an certificate has b irector, page 2 s autopsy 2 🖾 No Critical Limb Ischemia 1□ Yes Division or Vital al or Attending Physician: Ts after death.

I Director: After this certificated in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52503 10 - 9 - 0730. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD Shailesh Sheth

State Registrar 31. Date filed (Month, Day, Year)

OCT 1 2 2007

32. Registrar's Signature

			For State		State of M	larylan					Mer	ntal Hy	giene	e	01100
			Registrar	Film A Bai-t-W-	)		Cei	rtificat	e of De	eath	Lo		Reg. No	2007	34489
г	Physici /Medic		1. Decedent's Name (i	Dale	Queser	berry	,					Date of De Month Ctobe		0, 2007	3. Time of Death 4:04 a M
	Examir		4a. Facility Name (If no	ot institution, g	give street and number	)		4b. City,	Town, or Lo	ocation of Dea				. County of Death	
			Johns Ho	pkins	Hospital				altimo						
L	Funeral Director		5. Social Security Num 218-58-154	48	i. Sex 7. A 1 X M 2 □ F	ge (In yrs. I	last birthday) Yrs.	If Under Months		f Under 24 Hr Hours Mir	1.	Date of Bir (Month, Da Jan。 1	ıy, Year		place (State or Foreign intry) rginia
	and www.		Usual Residence of De 10a. State 1	ob. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho ied a	jo	MD	Calv	<i>z</i> ert		hesape	eake I	Beach						1 ☐ Yes 2 X No
	r 28a	rec	10e. Street and Numb					10f. Zip					10g. Ci	itizen of What Cou	intry?
	h with	a D	5001 Ch	ristiar	na Parran H	Road			207	732				U.S.A.	
	ems ser my	ner	11. Marital Status		12. Was Deceden Armed Forces	t Ever in U.	S. 13.1	Was Dece	dent of Hisp	anic Origin? ( Mexican, Pue	Specify	Yes or No	)-	14. Race - Amer Black, White	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 3 ☐ Widowed 4 [			] No		1 ☐ Yes		Specify:	710 1110	ari, 010.)	İ	Specify:	white
2-0	72 ho natur	Completed	(Specify	5. Decedent's	Education grade completed)		16a. Dece	dent's Usua	al Occupation	on ing most of w	orkina		16b. F	Kind of Business/I	ndustry
21	ithin ne.	ng l	Elementary/Second		College (1-4or	5+)	life.	DO NOT us	se retired)	ing most of w	orning				
	led w hygier her th	ပို	12 Tethada Nama (5)	rot Middle L	and l			super		2. Mathawa Ne		inak Biliniaka			g company
land	uld be fi fental F rked ot ic ever	To Be	17. Father's Name (Fit Walter	W •	Quesent	erry			18	3. Mother's Na Vir				rie	Cox
Maryland	d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r traumatic event, the Med		19a. Informant's Name			=0									<sup>ip Code)</sup> 20732 Beach, MD
e,	f and Healt em 2		20a. Method of Dispos		nberry, wii					la Fall	Date			ocation - City or 1	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.			Cremation 3	B □Removal from Stat		Place of Disponentery, creation Memoral			ns   10–1				kirk, MC	,
alti	permit. Pa Departmer Important: any Injury	-	21. Signature of Fune	ral Service Li	ced see	1	22	2. Name an	d Address	of Facility	Raus	sch Fi	uner	al Home,	P.A.
_	90 E 8 9		A)	ya/	( Hella	ih				rmony 1	_			, MD 20	736
	Physician		shock, or heart Immediate Cause (Pic	allere. List of	omplic tions that cause only one cause on each	line.	Do not ent	er the mod	e of dying,	such as cardi	ac or re	espiratory a	arrest,	1	Approximate Interval Between Onset and Death 10 days
	/Medical		disease or condition resulting in death)	- 4	a. <u>urem</u>		uence of):								
4	Examiner	L	Sequentially list condi	itions,	D	l fail									10 days
	rted nsit	Examiner	if any, leading to immediate. Enter Underly Cause (Disease or inputhat initiated events	ediate ing ury	Due to (or a		uence of):								1 month
Ć,	execun and ial-tra	Exar	that initiated events resulting in death) Las	st	C. Due to (or a										
8760,	icate be executed physician and s the burial-transit	dical			d. cirrl	nosis									1 year
Box 6	eath certif attending for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 months 1 ☐ Yes 2 ☐ N	onths?	23c. If yes, outcom 1⊟Live birth 4⊟Pregnant	2 Feta	Ideath 3[	]Ectopic pi ] Other (sp						23d. Date of deli	very Day Year
P.0	at the I by th stache	Phys	9 Unknown		9□Unknown						- 0				
Records,	w requires that the de been signed by the should be detached	ed by	Part II. Other significa	ant condition	s contributing to death	but not resu	ulting in the u	nderlying c	ause given	in Part I.		23e. Did 1			the cause of death?  bbably 4 ☐Unknown
000	law re as bee 2 sho	plet										24a. Was auto		24b. Were au	topsy findings available ompletion of cause of
<u>=</u>	sician: The law certificate has t irector, page 2 s	Com										perfo 1∐ Yes	ormed? 2 <b>∏</b> N	death?	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred examiner?		Hoonital					6. Place of De	eath (C	heck only	one)		
o	Phys this al dir	은	1 ☐ Yes 2 No.	)	Hospital: 1 Inpa 28a. Date of In		ER/Outpatier 28b. Time o							6 ☐Other (Spec	cify)
no	di <b>ng</b> l J. After funer	ioi	1 🛛 Natural	5 Pending investiga	(Month, D	lay Year)	Injury	M	8c. Injury a Work?	t s 2∐No	280	. Describe	now inji	ury occurred	
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be 280 Place of it	njury - At ho etc. <i>(Specif</i> )	ome, farm, str y)			2 2 110	28f.	Location ( City or To	Street a	and Number or Ru te)	ral Route Number,
	ospita hours uneral ily filled	Medical Co	29a. Certifier 11 (Check only 21 one)	Certifying Medical E	Physician: To the bes xaminer: On the basis and manner:	of examina	wledge, deat tion and/or in	h occurred vestigation	at the time, , in my opir	, date and pla nion, death oc	ce, and curred	I due to the at the time	e cause( , date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the H within 24 To the Fl complete	Mec	29b. Signature and titl	le of certifier	and manner:	Janou.		290	. License n	umber			29d. D	ate signed (Month	n, Day, Year)
	r>F0		1/	//	$\mathcal{X}$ .				RES-0	00				ober 10,	
	П		30. Name and addres	s of person w	ho completed cause of	death (Item	n 23a) (Type,			600 No:	rth	Wolf			
ren	1		Charles	F. Hai	nes, John	Hopki	ns Hos	pital		Baltim			212		
	Sta Regist		31. Date filed (Month,	Day, Year)	1 2 2007 Regis	tra Signa	ature	_					-		

				State of Maryla				•	•	
			1 - For State Registrar		Ce	rtificate of	Death	Re	19. No. 2 U U /	34490
	Physici	an	Decedent's Name (First, Middle, Last,					Date of Death     Month	Day Year	3. Time of Death
	/Media	cal	George 4a. Facility Name (If not institution, give	e Maxwell Ras	h, Sr.	4h Cihi Taura a	a Longtion of Dag		19, 2007 4c. County of Death	0710 A M
	Examir	ier	13 Reed Hartnett			E1kton	r Location of Dea	ın	Cecil	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs			place (State or Foreign
	Director		214-36-8300	X <sup>M 2□F</sup> 68_	Yrs.	Months Days	Hours Min	May 13,	1939 Peni	nsylvania
	within 72 hours after death with the Maryland ene. then "netural", or Iteme 23e or 28e-f ehow he Medical Examiner must be notified at		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. fnside City Limits
	Ba-f-e	ctor	Maryland Cecil	E	1kton					1 ☐ Yes 2 X No
	Vith th	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	intry?
	eath v	Funeral	13 Reed Hartnett	Street  12. Was Decedent Ever in U	10 12	21921	lisancia Origin? //	Pageifu Van as Na	United S	
10	ther d	Fun	11. Marital Status  1 □ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🕅 No			an, Mexican, Pue	Specify Yes or No- to Rican, etc.)	Black, White	
036	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh:	ite
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occup	during most of wo	orking	16b. Kind of Business/I	ndustry
121	within ane then	ldm	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		DO NOT use retired			County C	
<b>d</b> 2	Hygid Hygid Sther		17. Father's Name (First, Middle, Last)		Du	ilding In		me (First, Middle, M		overnment
<u>la</u> n	fental rked ric ev	To Be	George L. Rash				Gladys	s Greer		
Maryland 21215-0036	and N		19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailir	ng Address (Street	and Number or R	lural Route Number,	City or Town, State, Z	ip Code)
Z K	end sealth m 27 m 27 her tr		Beverly Rash/Wife				ett Stre		n, Marylan	
ŏ	iges 1 nt of H i if ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State St	cemetery, crey	osition (Name of matory or other place S Method:	ist Oct	ober	20c. Location - City or 1	own, State
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 le marked other then "netural", or iteme 23e or 28a-f ehow amy injury or other traumatic event, the Madical Examinet must be notified at Ance.		4 ☐ Donation 5 ☐ Other (Specify)  21. Sign ture of Funeral Service Licens	l Cer	neterv		23,	2007	Lewisville	Maryland
Ba	Depa Impo any i		100000000000000000000000000000000000000	Chilt	H 1	icks Home	for Fun	erals, P.	A. ton, Maryl	and 21021
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	stome of	C	ncer u	. I proto	Juses	)	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse			2 Naca	3,000		(a monius
	Examiner	1	Sequentially list conditions,	b. Due to (or as a conse	marana dh					
	uted Insit	Examiner	if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury	200 10 (01 03 0 00)139	quellos oij.					
2,092	e be executed rsicien and e burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
376		cal		d						
89 x	ertifica ling phy e as th	Med	IF FEMALE:							
Вох	eath certifi attending I for use as	lan/	in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3[	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
P.O.	that the death led by the atter detached for i	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	geath 5	Other (specify)				
	The law requires that the death certifica ete hes been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b	ed t	IDDM					1 ☐ Ye	os 2 No 3 □ Pro	bably 4 Unknown
မင္ပင	law reles be	Completed						24a. Was ar	y prior to d	topsy findings available ompfetion of cause of
E	: The cete h	Cou						perform 1 Tes 2		2 □ No
<u> </u>	sician certif irector	Be	25. Was case referred to medical examiner?	Hospital:	7500	a a DOA Oth		eath (Check only one		
ō	g Phy er this eral d	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of fnjury	ER/Outpatier 28b. Time o	f 28c. Injur	y at	28d. Describe ho	w infury occurred	uly)
ion	ath. rr: Afte	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆	Yes 2 □ No			
Division of Vital Records,	To the Hoepital or Attending Physician: The lav within 24 hours elter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, str ify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital within 24 hours e To the Funerel Completely filled		29a. Certifier 1X. Certifying Phy	sician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and plac	e, and due to the ca	ause(s) and manner as	stated
	n 24 h	Medical	(Check only one) Medical Exami	iner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time, da	ate and place, and due	to the cause(s)
	To the Tour	ž	29b. Signature and title of certifier	M.		29c. Licens	e number	29	9d. Date signed (Month	, Day, Year)
,			Cenal /		no.	D2	8628		10/22/0	7
	V		30. Name and address of person who co	V V	m 23a) (Type,	Print)	Cf 3	lut i	10.3192	,
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	J. ogr.	, 6	F/m in	W. dild	
*	Registr		OCT 2 6 20	07	de do	2000				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar			Marylaı	-			lealth a Death			Reg. No.	2007	34491	
	Physici /Medi		1. Decedent's Name (First, A PATRICE		ZICHA		14					2. Date of De Month	Day		3. Time of Death	
	Examir	ner	4a. Facility Name (If not insti SHADY GROVE 5. Social Security Number	0 /	ENTIST	HOSPE	THC.	Ro	, Town, or CKVI er 1 Year	Location of		0 D 4 Die	1	NON 160		
	Funeral Director		212-66-9167 Usual Residence of Deceder	1 5	M 2□F	54	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Oct 14,	iy, Year) 1952	Year) 1952 9. Birthplace (State or Foreign Country) France		
	Maryland B-f show	tor	10a. State 10b. Co		ery		ity, Town or Lo		g						10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	with the	Director	10e. Street and Number					10f. Z	ip Code					en of What Cou	•	
36	n 72 hours after deeth with the Maryland "natural", or iteme 23a or 28a-f show sidical Examinar must be notified at	by Funeral	10721 Game P1 11. Marital Status 1 Never Married 2 3 Widowed 4X Divo	Married	12. Was Deced Armed Ford 1 Yes 2	ces?			20879 edent of H ecify Cuba 2⊠ No	ispanic Ori In, Mexicar		ecify Yes or No Rican, etc.)	)- 14	nited S1  4. Race - Amen Black, White,	can Indian, etc.	
21215-0036	within 72 hou ene. then "netura he Medical E	Completed I		edent's Edu ighest grad	cation		16a. Dece	kind of w	ual Occupa ork done d use retired	during mos	t of worki	ng	16b. Kine	d of Business/Ir		
					1	401 34)	Sale	es As	socia					io/Video	)	
Maryland	id be filed ental Hyg ked other ic event,	To Be	17. Father's Name (First, Mic									(First, Middle, Richaud				
ary	and M and M is mar	۲	19a. Informant's Name/Rela			ther)	19b. Maili	ng Addre	ss (Street a					Town, State, Zij	Code)	
	ges 1 end 2 should t of Heelth and Mer if Item 27 is marks or other traumatic		Yvonne Richau 20a. Method of Disposition	ideau	Skidmon	1000						-			D 20879	
Baltimore,	Pages nent of h nt: if ite		1 ☐ Burial 2 ☑ Cremat 4 ☐ Donation 5 ☐ Othe	ion 3 ⊟R	lemoval from S		Place of Dispo cemetery, creating tropoli				0ct 200	_		ation · City or To andria,		
Salti	Department Department Important: any injury		21. Signature of Funeral Ser		1/	2						ol Fune			121	
	40 E # 9		23a. Part1. Enter the diseas	<b>Z</b> Y	WA	used the dea								ersburg	MD 20877	
Janes Comment	Pnysician /Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only or	a	en line. EMBI	CRHA		de or dyin	g, such as	cardiac				Interval Between	
	Examiner	_	Sequentially list conditions,	t	Due to (o	ras a consec BLV ras a consec	C	AB	SCI	Ξ2 <b>て</b>				LA CA	IWEEK	
5	cuted nd ransit	Examiner	Sequentially list conditions, 1 my, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	【。	DE	Hisc	ENCE	OF	- A	WAS	TOR	10515	. Elm	A DUCK	WEEK	
8760,	icate be executed physicien and s the burial-transit		resulting in death) Last		Due to (or as a consequence of):  d. RECTAL CANCER						1	CIP LARPROVED B	N MEDICAL	A DECINE	YEARS	
P.O. Box 6	Attending Physician: The law requires that the death certific rideath.  actor: After this certificate has been signed by the ettending p by the funeral director, page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						ERVICA	0,4		d. Date of deliv Month	ile ile	
rds, P	iw requires that s been signed b should be deta	۵	Part II. Other significant con META ST	ATTC	ntributing to dea	TAL	sulting in the u	nderlying ER	cause give	en in Part I.		23e. Did to		/	he cause of death? pably 4 □Unknown	
Division of Vital Records,	: The law r cate has be page 2 sh	Completed										24a. Was autor perfo 1 Yes		24b. Were auto prior to co death? 1  Yes	opsy findings available mpletion of cause of	
<u> </u>	sician: Th certificate irector, pag	o Be	25. Was case referred to me examiner	-	lospital: 📐 🔏		15D/0		OA Othe	ar.		(Check only o				
ion of	To the Hospitel or Attending Physician: whim 24 hours siter deals and the function of the Funeral Director. After this certific completely filled in by the funeral director.	atlon: To	27. Manner Ceath 1 Natural 5 ☐ Pe	nding estigation	28a. Date of	natient 2 Injury Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 ∐ Nu	2	ne 5 ☐ Resid 28d. Describe f		Other (Special occurred	(y)	
-	2 2 2 2	Certification:		uld not be termined	28e. Place o building	f Injury - At h g, etc. <i>(Speci</i>	iome, farm, str	reet, facto	ry, office		2	281. Location (S City or Tov		Number or Run	al Route Number,	
	Hospi 24 hou Funer stely fill	Medical	29a Certifier 1 ant (Check only one)	itying Phys ical Examir	ner: On the bas and manne	is of examina	uwludge, daat ation and/or in	h occurra vestigatio	at the time, in my op	e, date an pinion, deal	d place, a th occurre	and due to the ed at the time,	causa(s) a date and p	nd mannar as s place, and due to	tated. o the cause(s)	
-	To the Hospitel of within 24 hours el To the Funeral D completely filled is	Me	29b. Signature and title of ce	tifier	0/1	4		1	c. License					signed (Month,		
N .	10		▶ IJUACU	ac	( wes	3			05	9199			10	0-10-	0+	
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FFEMALE   23b. Was decedent pregnant in the past 1/2 months?   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Cother (specify)   23d. Date of delivery   Month   Day   Year   4   December   1   Year   2   No   3   Probably   4   Munch   No   4   Munch   No   1   Year   2   No   3   Probably   4   Munch   No   4   Munch   No   1   Year   2   No   3   Probably   4   Munch   No   4   Munch   No   1   Year   No   4   Munch   No   No   No   No   No   No   No   N	3760,	ate be executed sysician and he burial-transit	ical Examiner	that initiated events	Due to (or as a										
1   Yes   2   No   3   Probably   4   Muknown	Box 6	death certif e attending ed for use a	## 15 FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)												Year
State		quires that n signed b	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying	cause give	en in Part I.						
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   218.   218.   218.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229	al Reco	E 25 C	Complete								autop perfo	rmed?	prior to death	completion o	s available cause of
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   218.   218.   218.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229.   229	Vita	ician certifi rector		examiner?	Hospital:			Othe	ac .		10	700			
D34768 October 13, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jeffrey M. Wieland, M.D., Berlin Professional Ctr., 314 Franklin Ave., Berlin, MD 2183  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Physic this stal di			28a. Date of Injury	28b. Time o		UA	4 🗆 Nu					ecify)	
D34768 October 13, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jeffrey M. Wieland, M.D., Berlin Professional Ctr., 314 Franklin Ave., Berlin, MD 2183  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	<u>o</u>	nding ath. r: Afte e fune	atior	1 Natural 5 ☐ Pending	(Month, Day								,		
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D34768 October 13, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jeffrey M. Wieland, M.D., Berlin Professional Ctr., 314 Franklin Ave., Berlin, MD 2183  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		he Hospi n 24 hou ne Funer bletely fill		(Check only 2 Medical Exam	iner: On the basis of e	xamination and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, a	and due to the ead at the time,	cause(s date and	) and manner d place, and d	as stated. ue to the cause	<b>9</b> (s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jeffrey M. Wieland, M.D., Berlin Professional Ctr., 314 Franklin Ave., Berlin, MD 2181  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		To the To the Comp	Σ	29b. Signature and hitse of certifier	1 0		29	c. License	number			29d. Da	te signed (Mo	nth, Day, Year	)
Jeffrey M. Wieland, M.D., Berlin Professional Ctr., 314 Franklin Ave., Berlin, MD 2183	)			Mahal	and n	40		34768	3			0cto	ber 13	, 2007	
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	N -	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature				'			, -		

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and N	nental Hygi	iene 00	7 34493
ı	Physici	ian	Decedent's Name (First, Middle, Last)			E		2. Date of Death Month	n Day Ye	3. Time of Death
1	/Medi	cal	Sarah Yvonne R					10	13 200	
	Examir	ner	4a. Facility Name (If not institution, give s 18036 Herr Lane	street and number)			r Location of Death Onsboro		4c. County of D	ashington
	Funeral		Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		213-08-2742	M XDF 23	Yrs.	Months Days	Hours Min.	(Month, Day, June 12,		Mary Land
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	ò	Maryland Washin		y, roun or co	Boonsbo				1 Tyes XXNo
	r 28a-	Director	10e. Street and Number	19 1011		10f. Zip Code	10	10	g. Citizen of Wha	t Country?
	th with		18036 Herr Lane			2	1713			USA
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.		ispanic Origin? (Sc an, Mexican, Puerto	ecify Yes or No-		American Indian, Vhite, etc.
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes  No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify:	White
21215-0036	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28e-1 show The Medical Examiner must be notified at	ed b	15. Decedent's Educ		16a. Dece	ient's Usual Occup	ation		6b. Kind of Busine	
215	- 3	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done on NOT use retired	during most of work	ring		,
21	filed within Hygiene. other then rent, Ire M	Con	12		Ne	ever Empl	oyed		Never E	mployed
and	9 00 -	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N		
Z	should be nd Mental marked o	<sup>2</sup>	John Ronald Ros  19a. Informant's Name/Relationship (Type	seberry	10b Mailie	a Addross /Street	Tere		ne Hood	to Zie Code)
Maryland	lth an		Craig Hood - Uncl	•		ii i	ire Drive			
re,	es 1 and 2 should b of Health and Ment: fitem 27 is marked r other traumetic e		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other place			100 Location - City	
<u>m</u>	Pages nent of ant: If it ary or o		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emovar from State	nor Cem	-		9.2007 B	oonsboro	, Maryland
Baltimore,	permit. Pages Department of I Important: If it any injury or of once.		21. Signature of Fugeral Service License				riefræflity Hom			,,
	205 29		(sul su				<del>_</del>		<u>'</u>	rt, MD 21795
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deat ie cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Qnset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		lobla.	the ma				TYC.
В	Examiner			Due to (or as a conseq	derice oi):					Area .
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
	and trans	Examine	that initiated events c. resulting in death) Last							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	lical Ex		Due to (or as a conseq	dence or):					
687	ficate p phys	edic	d	,						
Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		ICatania araggana			23d. Date of	delivery
	e deat he ath	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de ned by the a detached		9 ☐ Unknown  Part II. Other significant conditions confi		ulting in the u	adopting course six	on in Dort I	22a Did tob	acco usa contribut	te to the cause of death?
ds,	res riginal	d by	Tarris significant conditions com	timbuling to death but not res	aiting in the or	idenying cause givi	en in raiti.			Probably 4 Unknown
COL	> 0	lete						24a. Was an	24h Ware	autopsy findings available
Vital Records,	The taw ate has b page 2 st	Completed						autopsy perform	prior deat	to completion of cause of h?
ital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one		Yes 2□ No
of V	S S	TOE	examiner? 1 ☐ Yes 2 ☑ No Ho	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	me 5 Resider	nce 6 Other (5	Specify)
o u	ing Ph After th uneral	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World		28d. Describe how	w injury occurred	
Division	l or Attending after death. Director: After in by the fune	lcat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome farm stre		Yes 2□No	28f Location /Str	eet and Number o	r Rural Route Number,
<u>&gt;</u>	after after Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)	ot, tactory, office		City or Town,	State)	Tributo Ivanbor,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer.		29a. Certifier 1 Certifying Physic (Check only 2 Medicel Exemin	sician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at the tin	ne, date and place,	and due to the ca	use(s) and manne	r as stated.
	To the H within 24 To the F complete	Medical	one)	and manner stated.	tion and/or in					``
	To Vitl	4	29b. Signature and title of certifier	01.11		29c. License			d. Date signed (M	
			30. Name and address of person ho cor	moleted course of death "	MO	( C	4166>		10-15-	07
3H	-0		A	Conneck	123a) (1ype, 1	Med	real Co	ime	benn	when mo
8	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa		9				
100	Registr	ar	UV1 T 0 70	107	1. It.	Della S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** EDMOND RUSSELL OF ARRELL SR. 4:10 P M OCTOBER 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing and Rehab Sandy Spring Montgomery 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 220-32-6723 69 Director Maryland Oct. 24 1937 Usual Residence of Decedent 10a. State 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Md. Montgomery Damascus 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8716 Damascus Road 20872 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No White Specify: Ś 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cab Driver Transportation other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, of Health and Mental H Itsm 27 is marked of other trsumatic systems Pages 1 and 2 should be Robbinette David Lyehue Russell Eatta Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Russell / Son 8716 Damascus Road, Damascus, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 SCremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. Metropolitan Crem. 10/13/07 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 21. Signature of Fundaral Service censes 22. Name and Address of Facility
Muriel H. Barber Funeral Home M-00470 Box 5038, Laytonsville, P. O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC COLON CANCER 6 MONTHS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physicien end for use as the burial-transit or Attending Physicism: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, /Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS

certificete director, this After th death.

Com Be 25. Was case referred to medical

3 Suicide

(Check only one)

Medical

Certification:

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Director: / within 24 hours after or To the Funeral Directompletely filled in by

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death | Check only one Hospital: Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier

6 Could not be

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signalure and little of certifier

29c. License number D 0035045 29d. Date signed (Month, Day, Year) OCTOBER 12, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers PHILIP G. HENJUM, M.D. 18109 PRINCE PHILIP DRIVE, #200, OLNEY, MD. 20832

State Registrar

31. Date filed (Month, Day, Year) OCT 1 5 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician Day Michael E. Reynolds 11-07 1850 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**√**M 2□F Months Days Hours 220-54-1782 58 9, 1949 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10h. County Yes 2 No MD Prince Georges Capitol Heights Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 9522 Beach Park St. USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Purthis E. Reynolds Norma Baker ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Dottellis 1093 Elon Dr. Bowie, Md 20720 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐Removal from State Chesapeake Crematory 10/15/07 Beltsville, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee Rendon/ Hale Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706 P. 1. Enter the diseals, or contrications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unit any one cause on each line. Immediate Cause (Final Lung Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2X No Be

**Physician** /Medical Examiner

**Funeral** 

Director

ral", or Items 23a or Examiner must be r

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural"; or Items 23a or 28a-f show

Ith and Menta 27 is marked traumatic e

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr.

3altimore, Maryland 21215-0036

physician and is the burial-trans attending p signed by the atte page 2 should

Certification: To

Medical

OCT 12

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pleted cause of the man (lem 23a) (Type, Print) 30. Name and address of Ferson who c

Divya Verma 3001 Hospital Dr. Cheverly, Md.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donald C. Rudd October 21, 2007 09:38 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**M** M 2□ F Hours 68 Director 210-30-2144 1939 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maruland Harkord Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3901 Rock Run Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Funeral 21078 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, the once. Ferrel Fuel Petroleum Industru 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Rudd Irene (Bostic) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 Rock Run Road, Havre de Grace, Maryland 21078
e of Disposition (Name of Date 20c. Location - City or Town, State Helen I. Rudd (Wise) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/23/2007 West Chester, PA 4 Donation 5 D Other (Specify) R.A. Ferris & Co. Signature of Funeral Service Licensee 22. Name and Address of Teillman Mitchell Smith Funeral Home 123 S. Washington St. Havre de Grace, HD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, beach g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dea to for sein expressionante off Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No autopsy performed Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fun

completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print 30. Name and address of person who completed cause 31. Date filed (Month. Registrar's Signature Year) State osel P Registrar 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dewey Richard Stout 2007 A M October 0420 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, JAN 19, 9. Birthplace (State or Foreign Days Hours Min. 1 ☑ M 2 ☐ F West Virginia 1943 233-66-4182 64 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 215 Nellies Corner Road 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Automobile College (1-4or 5+) Maintenance Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dewey James Stout Pauline Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther C. Stout/Wife 215 Nellies Corner Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place Conowingo Baptist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State October 22 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Conowingo, Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. metestati Immediate Cause (Final Rapiden disease or condition resulting in death) Due to (or as a consequence of): ~ Cu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chel Mal Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

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"natural", or Items 23a

Pages 1 and 2 should be filed within 72 hours after death

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Item 27 i

Important; if it any injury or o

Baltimore, Maryland 21215-0036

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Examiner

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The law requires that the death certificate be executed

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certificate

this

Physician:

or Attending

To the Hospital within 24 hours at To the Funeral C

filled

Physician/Medical

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Completed

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Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 ☐ Yes 2 ☑ No 27. Manner of Death

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

3 Suicide

4 ☐ Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2007 OCT 2 6

Registrar's Signature HOSPITAL September 1

State Registrar

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Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ROBERT Lee SELLERS Α 10 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 213-16-<u>5682</u> MD May 30,1922 Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1XXVes 2 □ No WV Hampshire Romney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 260 Everett Place 26757 USA 12. Was Decedent Ever in U.S. Armed Forces? 1次0 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by 3XXWidowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Government Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Mamie Sellers Frank Sellers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Rothmeyer (daughter) 34<u>52 S. Westwood</u> <u>Springfield, MO 65807</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department o Important: If i any injury or 10/22/07 4 ☐ Donation 5 ☐ Other (Specify) Omps Cremation Center Winchester, VA 21. Signature of Funeral Service Lig 22. Name and Address of Facility McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 ames 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dreumoffere Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 n 5 - 11 cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) patient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes P 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Section 300 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 26

2007

			For State Registrar	State of N	larylan	-	artment of tificate of		nd Mental H		.2007	34499
Ī	Physici /Medio		1. Decedent's Name (First, Middle, La Henry Paul Ste	etina					2. Date of I Month October	Death	av Year	3. Time of Death 3:50 a M
	Examir		4a. Facility Name (If not institution, given Manor Care—Potomac	re street and numbe	r)		4b. City, Town,			4	c. County of Death	1
A .	Funeral Director			Sex 7. A 11X M 2□ F	nge (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Days		4 Hrs. 8. Date of E Min. (Month, I March	Day, Year	r) Cou	place (State or Foreign intry) York
	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examiner must be notified at	Director	10a. State 10b. County  Maryland Montg	omery	10c. City	.Town or Lo				10-0		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23a or 3 nust be n	eral Dir	10e. Street and Number 4925 Battery La			C 10		20814	0.00	US.		
9036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1½ Yes 2 If Yes, Give Year or Dates	s? ] No		ras Decedent of f Yes, specify Cu I ☐ Yes 2 No		n? (Specify Yes or N Puerto Rican, etc.)	NO-	14. Race - Ameri Black, White Specify: Whi	, etc.
21215-0036	d within 72 h giene. er than "natu th. Medica	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)		5+)	(Give life. L	lent's Usual Occi kind of work don DO NOT use retir eral Cou	e during most o ed)	of working		Kind of Business/li Governme:	,
Maryland	2 should be filed and Mental Hygic is marked other raumatic event, it	To Be C	17. Father's Name ( <i>First, Middle, Last</i> Henry Stetina	)				18. Mother's	s Name <i>(First, Midd</i> B <b>ulka</b>			
	es 1 and 2 sho of Health and item 27 is ma other trauma		19a. Informant's Name/Relationship ( Joan Patricia St	,		4925	Battery	Lane,	or Rural Route Num Apt. 306,	Betl	nesda, MI	20814
Baltimore,	t. Partmer		20a. Method of Disposition  1	(y)	e	te of 1	sition (Name of natory or other pl Heaven C . Name and Add	emeters		Si	lver Spri	own, State
Ba	permi Depa Impo any Ir	) (	23a. Part . Enter the disease, or com shock, or heart failure. List only	aplications that cause	ed the death	F:	rancis J 00 Unive	. Coli rsity l		Silve	ome Inc. er Spring	Approximate
8760,	Physician and whician and physician and physician and the private transit the private transit transit.	lical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis Due to (or a b. Pneumon Due to (or a Chronic c. Due to (or a Prosthe	s a consequia s a consequint e consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a consequia s a	ence of): ction o	of Hip					Onset and Death
P.O. Box 68	eath certific attending p for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnan Other <i>(specify)</i>	су			23d. Date of delive Month	very Day Year
	n requires that the dibeen signed by the should be detached		Part II. Other significant conditions of Atherosclerotic Co	_		-		iven in Part I.				the cause of death?
al Records,	Physician: The law rathis certificate has be ral director, page 2 sho	Completed by	05.14						per 1□ Yes	opsy formed? 2(X:N	prior to co death?	opsy findings available ompletion of cause of 2□ No
Vital	ysicia s certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ient 2∏t	ER/Outpatien	1 3∏ DOA O	thor:	of Death <i>(Check only</i> sing Home 5□ Re		6 ∏Other (Spec	ifu)
Division or	ine ine	Certification: T	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		jury lay Year)	28b. Time of Injury	M 28c. Inju	ury at ork? ]Yes 2 □ No	28d. Describe			
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	building,	etc. (Specify	")	eet, factory, office		City or T	own, Stai		
	the Hos thin 24 ho the Fun mpletely	Medical	(Check only one)  2 Medical Example 1 Certifying Property 1 Certifying Property 2 Medical Example 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying Property 1 Certifying	nysician: To the bes miner: On the basis and manner s	of examinat	ion and/or inv	estigation, in my	opinion, death	place, and due to the occurred at the time	e, date ar	nd place, and due	to the cause(s)
	1011		> Seam		2	00-) :=	D355				ate signed (Month tober 11	
1			30. Name and address of person who Susan J. Miller, 31. Date filed (Month, Day, Year)	MD 8218	Wisco	nsin A	venue,	#305, B	Bethesda,	MD 2	0814	
	Sta Registr		OCT 1 2 20	07 Bour	e b	for	de					

			For State Registrar	State of Maryla	•	artment of F rtificate of I			Noo 0 0 "	31.500
	Physici	- 2	1. Decedent's Name (First, Middle, La Maggie Lucille	Shoop				2. Date of Death October	9, 2007 ear	1:00 p. M
Page 1	/Medic Examir		4a. Facility Name (If not institution, gi Laurel Regional			4b. City, Town, or Laurel	r Location of Death		4c. County of Dea	
Ī	Funeral Director				yrs. last birthday) 4 Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Oct. 20,1	912 Vi	rthplace (State or Foreign Country) rginia
	/aryland show ed at	o	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		City, Town or Lo					10d. Inside City Limits 1 □Yes 2 XNo
	3a or 28a-	irec	10e. Street and Number 11416 Edmonston R			10f. Zip Code 20705			g. Citizen of What C United St	•
36	be filed within 72 hours after death with the Maryland ital Hygiene.  id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
Baltimore, Maryland 21215-0036	ithin 72 hor ne. han "natur hadka E	Completed by	15. Decedent's E (Specify only highest g	Education rade completed)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired are Provi	during most of world) -	king	6b. Kind of Busines:  Rescent N	
and 21	be filed htal Hygi od other event, tl	8	17. Father's Name (First, Middle, Las Frank Johnson	t)	DayCa	Ste Hovi		e (First, Middle, M		orbery
Mary	and sud	2	19a. Informant's Name/Relationship Dale C. Duvall -						city or Town, State, , Marylar	
imore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 i any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ※Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	b. Place of Dispo cemetery, crei detropol:	matory or other plac	e) patory 10/		Oc. Location - City of Alexandri	a, Virginia
Balti	permit. Departr Importa any Inji		21. Signature of Funeral Service Lice	Hromas.						ryland 20705
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caused the cy one cause on each line.  Septicemi  Due to (or as a con	a	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 10/5/2007
	Examiner □ #	ner	Sequentially list conditions, if any, leading to immediate	b. Pneumonia  Due to (or as a con	sequence of):					
68760, 5	icate be executed physician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Seizure L Due to (or as a con Alzheimer	sequence of):	ase				
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
ds, P.O	uires that the signed by the detaction is the detaction in the detaction in the detaction is the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign	þ	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause giv	ren in Part I.			to the cause of death?  Probably 4 XUnknown
		Completed						24a. Was an autopsy perform	/ prior to	
·Vital	Physician; Th this certificate ral director, pag	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 X Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth	or.	th <i>(Check only one</i> ome 5 ☐ Resider	nce 6 □Other (Sp	necify)
ion or	nding Phy ath. r: After thi e funeral c	-	27. Manner of Death  1 Avatural  2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Wor		28d. Describe hov		,,
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of injury - A building, etc. (Sp	At home, farm, str pecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or I State)	Rural Route Number,
	e Hospit 124 hour ie Funera iletely fill	Medical		thysician: To the best of my aminer: On the basis of exar and manner stated.						
	To th withir To th	Me	29b. Signature and title of certifier	1Aug		29c. Licens	13668	29	0d. Date signed (Mo.	
1			30. Name and address of person wh Azher Hussain, M.				Park, Ma	eryland 2	20740	
F	Sta Regist	ate	31. Date filed (Month, Day, Year)  OCT 12	32. egistrar's S			·	-	.,	